



It's Your Choice: Reference Guide

Group Health Insurance Information

Participating Local Government Employees & Annuitants



ET-2128r-10 (10/09)

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State & Federal Notifications

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Notice of Privacy Practices for the STANDARD PLAN AND STATE MAINTENANCE PLAN (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.

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 (ETF) 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.

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 and to provide you with a notice of the above plans' duties and privacy practices. 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

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REVIEW THIS
DOCUMENTATION
CAREFULLY

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 and State Maintenance Plan. Navitus Health Solutions (Navitus) is the pharmacy benefit manager (PBM) for the prescription drug benefit program. WPS and Navitus are business associates and are required to safeguard your health information according to HIPAA's privacy regulation 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 new notice on our Web site: <http://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 by 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.

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;
- ☞ 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 law, including but 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 any time, 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(s) 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.

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(s) 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 since April 14, 2003. 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 (ETF)

Phone toll free: 1-877-533-5020 **Fax:** 608-267-0633

Local: 608-266-3285

Mailing Address for Written Correspondence:

ETF c/o Privacy Officer

P.O. Box 7931

Madison, WI 53707-7931

Secure E-mail Correspondence available by access our Internet Site at:

<http://etf.wi.gov/contact.htm>, click on the "EMAIL US" link.

Office for Civil Rights

Phone: 1-312-886-2359

Fax: 1-312-886-1807

TDD: 1-312-353-5693

Chicago Contact Information:

U.S. Department of Health & Human Services

233 N. Michigan Ave, Suite 240

Chicago, IL 60601

Effective date: October 9, 2006

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 State Employees and Wisconsin Public Employers (local government) Group Health Insurance Programs have 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 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.

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 for up to three years 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:

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 pre-existing 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.



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 three-year 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).

Additional information may be found under the *Frequently Asked Questions* section of this booklet.

HIPAA: PRIVACY, ELECTRONIC TRANSACTIONS STANDARDS, AND SECURITY

The federal Health Insurance Portability and Accountability Act (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 at 1-877-533-5020.

HIPAA: PRE-EXISTING CONDITIONS

HIPAA, effective January 1, 1998, is intended to make it easier for employees to change jobs by limiting waiting periods for coverage of pre-existing health conditions.

Under this health insurance program, employees who did not enroll for coverage when first offered but later enroll are limited to coverage under the Standard Plan with a 180-day waiting

period for preexisting conditions. As a non-federal, self-insured governmental plan, HIPAA allows this policy to continue. The Group Insurance Board has determined that this is necessary to avoid potential anti-selection.

HIPAA: SPECIAL ENROLLMENT OPPORTUNITIES

There are certain situations where the employee may enroll as a late enrollee without pre-existing condition restrictions, such as loss of other coverage, marriage and birth or adoption of a child. (See *Frequently Asked Question* section.)

INDEPENDENT REVIEW

In addition to the internal grievance process that all health plans are required to provide, 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, not medically necessary or due to a pre-existing condition exclusion denial or rescission of coverage. The amount or expected cost of treatment must exceed \$296.

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

NATIONAL MEDICAL SUPPORT NOTICE

State and Federal law 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 may provide for 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/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.

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; 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.

Patient's Rights & Responsibilities

PATIENT'S 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.



Patient's Rights & Responsibilities

The following is a summary of your rights and responsibilities.

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 booklet. 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, 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 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 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 18 years of age 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 the Department of Employee Trust Funds, in care of the Office of Legislative Affairs, Communications and Quality Assurance. You will need to submit a 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.

YOU HAVE THE FOLLOWING RESPONSIBILITIES

- During the It's Your Choice Enrollment period, to review the It's Your Choice book and information provided by your plan. 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 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 dependent eligibility if you have a dependent child who is at least 19 years of age and is a full-time student or is disabled.

Coverage for dependents could be lost if the questionnaire is not returned to the plan.

- 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.

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Frequently Asked Questions

GENERAL INFORMATION

1. Who is eligible for Wisconsin Public Employers' Group Health Insurance?

Information about the Wisconsin Public Employers' Group Health Insurance program in this guide applies to the following individuals whose employer has elected this coverage:

- Active employees participating in the Wisconsin Retirement System (WRS).
- Retired employees who are receiving an annuity from the WRS (including a lump sum or disability annuity) and who were participants in the employer's preceding group health plan.
- Insured employees who terminate employment after age 55 (age 50 for protectives) and who have 20 years of creditable service.
- The surviving insured spouse of an insured employee or an insured retiree.

INSURANCE COMPLAINT PROCESS

2. What if I have a complaint about my health plan or Pharmacy Benefit Manager?

Each of the plans participating in the State of Wisconsin health insurance program is required to have a complaint and grievance resolution procedure in place to help resolve participants' problems. Your plan has information on how to initiate this process. You must exhaust all of your appeal rights through the plan. If the plan upholds its denial, it will state in its final decision letter your options if you wish to proceed further.

Depending on the nature of your complaint, you may be given rights to request an independent review through an outside organization approved by the Office of the Commissioner of Insurance. This option becomes available when a plan has denied services as either not medically necessary or experimental or due to a pre-existing condition exclusion denial or rescission of coverage. **Note:** If you choose to have an independent review organization (IRO) review the plan's decision, that decision is binding on both you and your plan except for any decision regarding a

pre-existing condition exclusion denial or the rescission of coverage. Apart from these two exceptions, you have no further rights to a review through the Department of Employee Trust Funds once the IRO decision is rendered.

3. How can the Department of Employee Trust Funds (ETF) help me if I disagree with my health plan's grievance decision?

As a member of the State of Wisconsin group health insurance program, you have the right to request an administrative review through ETF if an IRO has not rendered a decision on your grievance that is final and binding as described above. To initiate an ETF review, you may call or send a letter to ETF and request an insurance complaint form (ET-2405). Complete the ETF complaint form and attach all pertinent documentation, including the plan's response to your grievance.

Please note that ETF's review will not be initiated until you have completed the grievance process available to you through the plan. After your complaint is received, your complaint is acknowledged and information is obtained from the plan. An ombudsperson in the Office of Legislative Affairs, communications and Quality Assurance will review and investigate your complaint and attempt to resolve your dispute with your plan. If the ombudsperson is unable to resolve your complaint in your favor, you will be notified of additional administrative review rights available through the Department.

4. What steps do I follow to enroll in the health insurance program?

You will want to:

- Determine which plans have providers in your area.
- Contact the health plans directly for information regarding available physicians, medical facilities, and services.
- Review the health plan Rates, Report Card Information and the Plan Descriptions located in the *It's Your Choice: Decision Guide*.

ENROLLING FOR
COVERAGE

- File an application. Employees should file with their benefits/payroll/personnel office within the required enrollment period.

5. When does my coverage go into effect as a new employee?

If eligible, you may enroll for single or family coverage in any of the available health plans without restriction or waiting periods for pre-existing medical conditions, provided you file a health application with your benefits/payroll/personnel office within the required enrollment period stated below:

1. Within 30 days of your date of hire in an eligible position. Coverage will be effective the first day of the month on or following receipt of the application by your employer, or
2. Within 30 days prior to the date, the employer contributes to the premium, with coverage becoming effective when you become eligible for employer contribution.

There are no interim effective dates except as required by law. However, you may enroll for single coverage within 30 days of your date of hire and change to family coverage if your application is received prior to the date the employer contributions begin.

If you cancel your policy prior to the date that the employer contribution starts, you may re-enroll in health insurance with the new coverage becoming effective on the first day of the month that employer contribution begins.

You cannot assume that the month when your first payroll deduction occurs is the month when your coverage begins. Health premiums are deducted two months in advance of coverage. For further information on deductions and coverage, effective dates contact your benefits/payroll/personnel office.

Important information for Less Than Half-Time Employees:

The initial enrollment opportunity for most employees begins with their participation under the Wisconsin Retirement System (WRS). However, if you are less than half-time employee, you have another enrollment period if:

1. There has been a **30 day** termination of employment break; or
2. Your hours of employment increase and you qualify for a higher share of employer contribution toward health insurance premiums; or
3. You are appointed to a permanent position and you now qualify for the full share of employer contributions.

If you apply for coverage within **30 days** of one of these events, coverage will be effective on the later of the first of the month following the employer's receipt of the application or the effective date of the increase in the employer contribution. Retroactive effective dates are not allowed. This does not provide an opportunity to change from single to family coverage.

You may enroll at any other time, but will be restricted to the Standard Plan with a **180 day** waiting period for pre-existing conditions.

OTHER ENROLLMENT OPPORTUNITIES

6. Are there other enrollment opportunities available to me after my initial one has expired?

You may be able to get health insurance coverage if you are otherwise eligible under specific circumstances as described below:

- If you are an active employee and you and/or your dependent(s) are not insured under the Wisconsin Public Employers' Group Health Insurance program because of being insured under a group health insurance plan elsewhere, you may take advantage of a special **30 day** enrollment period to become insured in the State Group Health Insurance program without waiting periods for pre-existing conditions if:
 1. Your eligibility for that other coverage is lost or the employer's premium contribution for the other plan ends, or
 2. You and/or your dependents lose medical coverage:
 - Under medical assistance (Medicaid); or
 - Upon return from active military service with the armed forces. Employees must return to employment within **180 days** of release from active duty. You are entitled to enroll regardless of the coverage in effect. Coverage is effective on the date of your re-employment, or
 - As a citizen of a country with national health care coverage comparable to the Standard Plan.

The enrollment period begins on the date the other group health insurance coverage terminates because of loss of eligibility (for example, termination of employment, divorce, etc., but not voluntary cancellation of coverage) or the employer's premium contribution ends.

- If you are currently enrolled in the Wisconsin Public Employers' Group Health Insurance program with single

coverage, because your dependents are insured under a group health insurance plan elsewhere, and eligibility for that coverage is lost, or the employer's premium contribution for the other plan ends, you may take advantage of a special **30 day** enrollment period to change from single to family coverage without waiting periods for pre-existing conditions. Coverage will be effective on the date the other coverage or the employer's premium contribution ends.

- If you are not insured under the Wisconsin Public Employers' Group Health Insurance program and have a new dependent as a result of marriage, domestic partnership, birth, adoption, placement for adoption, you may enroll if coverage is elected within 30 days of marriage or effective date of the domestic partnership, or 60 days of the other events. Coverage is effective on the date of marriage, birth, adoption, or placement for adoption. Domestic partnership coverage is effective the date ETF receives the complete Affidavit of Domestic Partnership.
- If you and/or your dependents lose medical coverage under the Children's Health Insurance Program (CHIP) or become eligible to participate in a premium assistance program, you will have an opportunity to enroll in the Wisconsin Public Employers' Group Health Insurance program without waiting periods for pre-existing conditions by filing an application within 60 days of the loss of eligibility or the date you become eligible for premium assistance and by providing evidence satisfactory to ETF.
- If you do not enroll during a designated enrollment period, you may still get health insurance coverage if you are otherwise eligible. However, you (and your insured dependents if you elect family coverage) will be limited to the Standard Plan and will have a **180-day** waiting period for all pre-existing medical conditions except pregnancy. The waiting period applies to all conditions, which existed prior to the effective date of coverage under the Standard Plan, including all hospital confinements or inpatient charges related to pre-existing conditions for which confinement begins within the 180 day waiting period. For example, if a hospital confinement for a pre-existing heart condition begins on the 170th day of the waiting period and ends on the 200th day, none of the costs associated with the confinement would be covered. The waiting period does not apply to pregnancy terminated without childbirth.

EMPLOYEES

7. How are my health benefits affected by changes in employment status?

Layoff/Leave of Absence

Continuation of Coverage. Coverage may be continued for up to three years while you remain in employee status but receive no salary (limited to layoff or approved leave of absence). Arrangements for premium payment must be made with your personnel or payroll office prior to the time the layoff/leave of absence begins. A leave of absence is not considered ended until you have terminated employment or have resumed employment for at least 50% of what is considered your normal work time for that employer for **30 consecutive calendar days**. If coverage is not continued during layoff/leave of absence, there are no continuation rights if employment terminates.

Reinstatement of Coverage. If your health coverage lapses during your leave or layoff due to non-payment of premiums, you must submit a new application within **30 days** of returning to payroll to reinstate the lapsed coverage. Coverage will be effective the first of the month after the application is received by your payroll office. If an It's Your Choice Enrollment period has occurred while you were on leave, you will be offered an enrollment opportunity upon your return. *(See Question 6: Are there other enrollment opportunities available to me after my initial one expires?)*

Lapsed coverage can also be reinstated for an employee who has been on a leave of absence and who is entitled to, and applies for, an immediate annuity. Coverage shall be effective the first day of the calendar month which occurs on or after the date, the annuity application is approved by Employee Trust Funds, provided an application for health insurance has been received by that date.

If you occupy a seasonal or teaching position and do not receive pay between the end of one term of service and the beginning of another, your coverage may continue if you authorize a payroll deduction before your earnings are interrupted or make other provisions to pay premiums in advance.

Termination of Employment

Coverage will end on the last day for which premiums are paid. *(See CONTINUATION OF HEALTH COVERAGE.)*

Appealing a Discharge

Coverage may be continued if you have terminated from employment and are appealing discharge. The first premium payment and the appeal must both be filed within **30 days** of discharge. Premium payments must be made through your employer and be received at least **30 days** prior to the end of the period for which premiums were previously paid. You must pay the gross amount of premium due until the appeal is resolved. If the appeal is resolved in your favor, the amount normally considered employer contribution will be refunded to you.

Retirement

If you are covered when you retire, the health benefit plan will automatically continue if your retirement annuity from the WRS begins within **30 days** after employment ends. If you are eligible for Medicare, effective dates must be provided before coverage continues. (Those enrolled in SMP will be switched to the Standard Plan if Medicare eligible.) You must fill out the employer verification form and return it with your retirement application.

NOTE: If you are eligible for Medicare, you must be enrolled in the hospital (Part A) and medical (Part B) portions of Medicare at the time of your retirement. Enrollment in the prescription drug portion (Part D) is voluntary. If you do not enroll for all available portions of Medicare (A, B, and D) upon retirement, you may be liable for the portion of your claims that Medicare would have paid on the date Medicare coverage would have become effective. *(See the Medicare Information provided in the Q&A Section of this Guide.)*

Premium rates for retired employees are the same as for the active employees (except that your premium will decrease when you or a dependent becomes covered by Medicare). The employer may, at its option, pay all or a portion of the premium. If any portion of the premium is employer-paid, you must remit your portion of the premium directly to the former employer. If/when your employer does not pay any portion of the premium, the premium will be deducted from your monthly annuity. If the annuity is not sufficient to allow a premium deduction, you will be billed directly.

RE-EMPLOYED ANNUITANTS

8. How are my health benefits affected if I return to work for an employer not under the WRS)?

If you return to work for a non-WRS participating employer after retirement, your WRS annuity and health benefits will not be affected.

9. How are my health benefits and premiums affected if I return to work for an employer who is under the WRS?

If you return to work for a WRS participating employer, you may be eligible to once again become an active WRS employee. If you make this election and become an active WRS employee, your annuity will be cancelled and you will no longer be eligible for health insurance as a retiree/annuitant. You will be eligible for health insurance as an active WRS employee through your WRS participating employer if the employer is participating in an ETF health plan. Check with your employer to make sure you have other health insurance coverage available before you elect WRS participation.

You may also waive or terminate enrollment under Medicare until the first Medicare enrollment period after active WRS employment ceases. Your premium rates while covered through active employment will be the active employee rates shown in the It's Your Choice Decision Guide, not the Medicare rates.

When you subsequently terminate employment and resume your annuity, your eligibility for Wisconsin Public Employers group health coverage is once again dependent on your meeting the requirements for newly retired employees (that is, you must be insured under the state or WPE group insurance and you must apply for an immediate annuity from the WRS).

DEPENDENT ELIGIBILITY

10. Who is eligible as a dependent if I select family coverage?

- Your spouse or domestic partner.
- Your children who are not married and not eligible for coverage under a group health insurance plan that is offered by their employer and for which the amount of their premium contribution is not greater than the premium amount for their coverage under this program. Children include:
 1. Your natural children.
 2. Stepchildren or children of your domestic partner.
 3. Adopted children and pre-adoption placements. Coverage will be effective on the date that a court makes a final order granting adoption by the subscriber or on the date the child is placed in the custody of the subscriber, whichever occurs first. These

DEPENDENT
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dates are defined by Wis. Stat. § 632.896. If the adoption of a child is not finalized, the insurer may terminate coverage of the child when the adoptive placement ends. Legal wards that become your permanent ward before age 19. Coverage will be effective on the date that a court awards permanent guardianship to you (the subscriber).

Note: Children may be covered until the end of the month in which they turn 27.

Coverage may continue beyond that when children:

1. Have a disability of long standing duration, are dependent on you, or the other parent, for at least 50% of support and maintenance, and are incapable of self-support, or
 2. Are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education.
- Your grandchildren born to your insured dependent children may be covered until the end of the month in which your insured dependent (your grandchild's parent) turns age 18. Your child's eligibility as a dependent is unaffected by the birth of the grandchild.

IMPORTANT NOTE: There are tax consequences to you when you provide coverage for dependents that do not meet the support test for federal income tax purposes, for example, domestic partners and adult children that are not dependent on you, or the other parent, for at least 50% of their support and maintenance.

11. What if my spouse/domestic partner and I work for the same employer?

Your employer may determine whether married employees or domestic partners may each elect single or family coverage or if they are eligible only for family coverage through one of the spouses or domestic partners.

12. What if I have a child who is, or who becomes physically or mentally disabled?

If your unmarried child has a physical or mental disability that is expected to be of long-continued or indefinite duration, and is incapable of self-support, he or she may be eligible to be covered under your health insurance through our program.

You must work with your health plan to determine if your child meets the disabled dependent eligibility criteria. If disabled dependent status is approved by the plan, you will be contacted annually to verify the dependent's continued eligibility.

If your child loses eligibility for coverage due to age or loss of student status, but you are now indicating that the child meets the disabled dependent definition, eligibility as a disabled dependent must be established before coverage can be continued. If you are providing at least 50% support you must file a *Health Insurance Application/Change* form (ET-2301) with your employer to initiate the disability review process by the health plan. Your dependent will be offered COBRA continuation*.

If your disabled dependent child, who has been covered due to disability, is determined by the health plan to no longer meet their disability criteria, the plan will notify you in writing of their decision. They will inform you of the effective date of cancellation, usually the first of the month following notification and your dependent will be offered COBRA continuation*. If you would like to appeal the plan's decision, you must first complete the plan's grievance procedure. If the plan continues to deny disabled dependent status for your child, you may appeal the plan's grievance decision to ETF by filing an *Insurance Complaint* form (ET-2405).

***Electing COBRA continuation** coverage should be considered while his or her eligibility is being verified. If it is determined that the individual is not eligible as a disabled dependent, there will not be another opportunity to elect COBRA. If it is later determined that the child was eligible for coverage as a disabled dependent, coverage will be retroactive to the date they were last covered, and premiums paid for COBRA continuation coverage will be refunded.

13. What if I don't have custody of my children?

Even though custody of your children may have been transferred to the other parent, you may still insure the children if the other dependency requirements are met.

14. When does health coverage terminate for my dependents?

Coverage for dependent children who are not physically or mentally disabled terminates on the earliest of the following dates:

- The date eligibility for coverage ends for the subscriber.

- The end of the month in which:
 1. The child marries.
 2. Coverage for the grandchild ends when your child (parent of grandchild) ceases to be an eligible dependent or becomes age 18, whichever occurs first. The grandchild is then eligible for continuation coverage.
 3. Coverage for a spouse and stepchildren under your plan terminates when the divorce was entered.
 4. Coverage for a domestic partner and children of your domestic partner terminates when the ETF Affidavit of Termination of Domestic Partnership is filed.
 5. The child turns age 27.
 6. The child ceases to be a full-time student, and is age 27 or older.

See *CONTINUATION OF HEALTH COVERAGE* for information on continuing coverage after eligibility terminates.

FAMILY STATUS CHANGES

15. When do I notify my employer if a dependent loses eligibility for coverage?

Under Federal Law, if notification is not made within 60 days of the later of (1) the event that caused the loss of coverage, or (2) the end of the period of coverage, the right to continuation coverage is lost. You have the responsibility to inform your employer of any dependents losing eligibility for coverage under the Wisconsin Public Employers' Group Health Insurance program. If you have changed marital status, or you or your spouse/domestic partner have changed addresses, complete a new application as notification of this change. A voluntary change in coverage from a family plan to a single plan does not create a continuation opportunity.

16. What family changes need to be reported?

You need to report the following changes to your benefits/ payroll/personnel office within 30 days of the change. Annuitants and Continuants will need to contact ETF. Failure to report changes on time may result in loss of benefits or delay payment of claims.

- Change of name, address, telephone number, and Social Security number, etc.
- Obtaining or losing other health insurance coverage
- Addition of a dependent (within 60 days of birth or adoption)

- Loss of dependent's eligibility
- Marriage/domestic partnership
- Divorce/termination of a domestic partnership
- Death (Contact ETF if dependent is your named survivor.)
- Eligibility for Medicare

17. What action do I need to take for the following personal events (marriage, birth, etc.) and what restrictions apply?

Marriage

You can change from single to family coverage to include your spouse (and stepchildren if applicable) without restriction provided your *Health Insurance Application/Change* form (ET-2301) is received within **30 days** after your marriage, with family coverage being effective on the date of your marriage.

If you were enrolled in family coverage before your marriage, you need to complete a *Health Insurance Application/Change* form as soon as possible to report your change in marital status, add your new spouse (and stepchildren) to the coverage, and if applicable, change your name. In most cases, coverage for the newly added dependent(s) will be effective as of the date of marriage. (See *Question 11: What if my spouse/domestic partner and I work for the same employer?*)

Note: You may also change health plans if you, the subscriber file an application within 30 days of the marriage with coverage effective on the first day of the month on or following receipt of the application.

Domestic Partnership

You can change from single to family coverage to include your eligible domestic partner (and his/her eligible children if applicable) when you submit an Affidavit of Domestic Partnership to ETF with a copy of it and a *Health Insurance Application/Change* form (ET-2301) to your employer if actively working, or to ETF for annuitants, within **30 days** of the date ETF receives a completed Affidavit of Domestic Partnership. Coverage will be effective on the day ETF receives the completed Affidavit of Domestic Partnership.

If you were enrolled in family coverage before your domestic partnership, you need to complete an ETF Affidavit of Domestic Partnership and a *Health Insurance Application/Change* form as soon as possible to report your change

in status and add your new domestic partner (and his/her eligible children) to the coverage. (See *Question 11: What if my spouse/domestic partner and I work for the same employer?*)

Birth/Adoption/Legal Guardianship/Dependent Becoming Eligible

If you already have family coverage, you need to submit a *Health Insurance Application/Change* form to add the new dependent. Coverage is effective from the date of birth, adoption, legal guardianship, or when a dependent becomes eligible and otherwise satisfies the dependency requirements. Be prepared to submit documentation of guardianship, paternity, or other information as requested by your employer.

If you have single coverage, you can change to family coverage with your **current health plan** by submitting an application within **30 days** of the date a dependent becomes eligible or legal guardianship is granted, or within **60 days** of birth or adoption.

Note: You may also change health plans if you, the subscriber file an application within 30 days of a birth or adoption with coverage effective on the first day of the month on or following receipt of the application.

Single mother or father establishing paternity

An insured single parent may cover his or her dependent child, effective with the child's birth or adoption, by submitting a timely application changing from single to family coverage.

Children born outside of marriage become dependents of the father on the date of the court order declaring paternity or on the date the "Voluntary Paternity Acknowledgment" (form HCF 5024) is filed with the Department of Health and Family Services or equivalent if the birth was outside the state of Wisconsin. The effective date of coverage will be the date of birth if a statement of paternity is filed within **60 days** of the birth. If more than **60 days** after the birth, coverage is effective on the first of the month following receipt of the application.

A single mother may cover the child under her health plan effective with the birth by submitting an application changing from single to family coverage.

Upon order of a Federal Court under a National Medical Support Notice

This can occur when a parent has been ordered to insure

his/her eligible child(ren) who are not currently covered. You will need to submit an application to your benefits/payroll/personnel office with coverage becoming effective on either:

- The first of the month following receipt of application by the employer, or
- The date specified on the Medical Support Notice.

Divorce

Your ex-spouse (and stepchildren) can remain covered under your family plan only until the end of the month in which the marriage is terminated by divorce or annulment, or to the end of the month in which the continuation notice (ET-2311) is provided to the divorced spouse, if family premium continued to be paid, whichever is later. (In Wisconsin, a legal separation is unlike divorce in that it does not affect coverage under the Wisconsin Public Employers' group health insurance program.) The divorce is usually entered on the hearing date regardless of when the judge files papers or papers are signed by the parties. You should notify your payroll office prior to the divorce hearing date. If you fail to provide notice of divorce timely, you may be responsible for premiums paid in error which covered your ineligible ex-spouse and stepchildren. Your ex-spouse and stepchildren are then eligible to continue coverage under a separate contract with the group plan for up to **36 additional months**. Conversion coverage would then be available. You can keep your dependent children and adopted stepchildren on your family plan for as long as they are eligible (age, student status, etc.). (See *CONTINUATION OF HEALTH COVERAGE*.)

You must file a health application with your employer to change from family to single coverage. File a *Health Insurance Application/Change* form with your employer to remove ineligible dependents from a family contract.

When both parties in the divorce are employees or annuitants, and each party is eligible for this health insurance in his or her own right, and is insured under the this program at the time of the divorce, each retains the right to continue this health insurance coverage regardless of the divorce (unless the employer withdraws from this program).

The participant who is the subscriber of the insurance coverage at the time of the divorce must submit a health application to remove the ex-spouse from his or her coverage and may also elect to change to single coverage.

The participant insured as a dependent under his or her ex-spouse's insurance must submit a health application to establish coverage in his or her own name. The ex-spouse must continue coverage with the same plan unless he or she moves out of the service area (e.g., county). The application must be received by his or her benefits/payroll/personnel office within **30 days** of the date of the divorce.

Each participant may cover any eligible dependent children (not former stepchildren) under a family contract. Coverage of the same dependents by both parents would be subject to Coordination of Benefits provisions. Refer to Uniform Benefits in this Guide (your plan benefit certificate) or contact your health plan directly for information on Coordination of Benefits policies and procedures.

Note for active employees: Failure to apply timely will limit available coverage to the Standard Plan with a **180 day** waiting period for pre-existing medical conditions (except pregnancy).

Note for annuitants: If you fail to enroll within 30 days of the date of divorce have no enrollment or continuation rights. *(See Question 6: Are there other enrollment opportunities available to me after my initial one has expired?)*

Termination of a domestic partnership

Your former domestic partner (and eligible children of a domestic partnership) can remain covered under your family plan only until ETF receives your Affidavit of Termination of Domestic Partnership. If you fail to provide notice of termination of the domestic partnership timely, you may be responsible for premiums paid in error which covered your ineligible former domestic partner and eligible children of a domestic partnership. After termination, your ex-domestic partner and ineligible children of the domestic partnership are then eligible to continue coverage under a separate contract with the group plan for up to **36 additional months**. Conversion coverage would then be available. You can keep your dependent children and adopted children/stepchildren on your family plan for as long as they are eligible (age, student status, etc.). *(See the CONTINUATION OF HEALTH COVERAGE Section for further information.)*

When both parties in the domestic partnership are employees or annuitants, and each party is eligible for this health insurance in his or her own right, and is insured under this program at the time of the termination, each retains the right to continue this health insurance coverage (unless the

employer withdraws from this program). Upon termination of a domestic partnership, an affidavit must also be filed, in addition to a *Health Insurance Application/Change* form.

The participant insured as a dependent under his or her former domestic partner's insurance must submit a *Health Insurance Application/Change* form to establish coverage in his or her own name. The former domestic partner must continue coverage with the same plan unless he or she moves out of the service area (e.g., county). The application must be received by his or her benefits/payroll/personnel office within **30 days** of ETF receiving the Affidavit of Termination of the Domestic Partnership.

Each participant may cover any eligible dependent children (not former dependents who lost coverage due to a terminated domestic partnership) under a family contract. Coverage of the same dependents by both parents would be subject to Coordination of Benefits provisions. Refer to the Uniform Benefits (your plan's benefit certificate) in this guide or contact your health plan directly for information on Coordination of Benefits policies and procedures.

Note for active employees: Failure to apply timely will limit available coverage to the Standard Plan with a **180 day** waiting period for pre-existing medical conditions (except pregnancy).

Note for annuitants: If you fail to enroll within 30 days of the date of divorce have no enrollment or continuation rights. (*See Question 6: Are there other enrollment opportunities available to me after my initial one has expired?*)

Medicare Eligibility

You will want to refer to the Medicare information in the Guide for details regarding Medicare eligibility and enrollment requirements.

Death

Surviving Dependents. If an active or retired employee with family coverage dies, the surviving insured dependents shall have the right to continue coverage for life under the Wisconsin Public Employers' program at group rates. The Dependent children may continue coverage until eligibility ceases if they:

- Were enrolled at the time of death, or
- Were previously insured and regain eligibility, or
- Are a child of the employee and born after the death of the employee.

Health insurance coverage will automatically continue for your covered surviving dependents. Continued coverage will be effective on the first of the month after the deceased participant's date of death. Surviving dependents may voluntarily terminate the health insurance coverage by providing written notification to ETF and the coverage will terminate on the last day of the month in which their written request is received by the Department.

If the surviving dependent(s) terminates coverage for any reason he or she may not re-enroll later.

Note: The survivors may not add persons to the policy who were not insured at the time of death unless the survivor is also a state or WPE employee and eligible for the insurance in his or her own right.

If single coverage was in force at the time of death, the full monthly premiums collected for coverage months following the date of death will be refunded. No partial month's premium is refunded for the month of coverage in which the death occurred. Surviving dependents are not eligible for coverage.

18. When can I change from family to single coverage?

You may change from family to single coverage at any time with the change being effective on the first day of the month on or following receipt of your application by your benefits/payroll/personnel office. Switching from family to single coverage is deemed to be a voluntary cancellation of coverage for all covered dependents. Voluntary cancellation is not considered a "qualifying event" for continuation coverage.

HEALTH PLAN INFORMATION

19. When and how must I notify my health plan of various changes?

All changes in coverage are accomplished by completing an approved *Health Insurance Application/Change* (ET-2301) within 30 days after the change occurs. Always file an application through your benefits/payroll/personnel office to notify your plan of changes. Failure to report changes on time may result in loss of benefits or delay payment of claims. The changes to be reported are (*See Question 16: What family changes need to be reported?*):

- Change in plan (for example, from HMO to Standard Plan)
- Change in plan coverage (for example, from Single to Family)
- Name change
- Change of address or telephone number
- Addition/deletion of a dependent to an existing family plan
- Changing primary physicians within an HMO network

20. How do I receive health care benefits and services?

You will receive identification cards from the plan you select. If you lose these cards or need additional cards for other family members, you may request them directly from the plan. Alternate Plans are not required to provide you with a certificate describing your benefits. The Uniform Benefits section in this guide provides this information and will serve as your certificate.

Present your identification card to the hospital or physician who is providing the service. Identification numbers are necessary for any claim to be processed or service provided. For some plans including the Standard Plan and SMP, it is recommended or required that you or your physician must contact the health plan before you are admitted to a hospital. Check with your plan and make sure you understand any requirements.

Most of the alternate plans also require that non-emergency hospitalizations be prior authorized.

21. Will an HMO cover dependent children who are living away from home?

Only if the HMO offers service in the community in which the child resides. Emergency or urgent care services are covered wherever they occur. However, non-emergency treatment must be received at a facility approved by the HMO. Outpatient mental health services and treatment of alcohol or drug abuse may be covered. Refer to the Uniform Benefits in this guide. Contact your HMO for more information.

22. How do I file claims?

Most of the services provided by an HMO do not require filing of claim forms. However, you may be required to file claims for some items or services. The Standard Plan and SMP require claims incurred in any calendar year to be received by the Administrator no later than the end of the

next calendar year. Alternate plans (HMO's) require claims be filed within 12 months of the date of service, or if later, as soon as reasonably possible.

23. How are my benefits coordinated with other health insurance coverage?

When you are covered under two or more group health insurance policies at the same time, and both contain coordination of benefit provisions, insurance regulations require the primary carrier be determined by an established sequence. This means that the primary carrier will pay its full benefits first; then the secondary carrier would consider the remaining expenses. *(See the Coordination of Benefits Provision found in the Uniform Benefits Section of this Guide.)* It should be noted that with coordination of benefits the secondary carrier may not always cover all of your expenses that were not covered by the primary carrier.

PROVIDER INFORMATION

24. Does an HMO cover care from physicians who are not affiliated with the plan?

Most HMO plans will pay nothing when non-emergency treatment is provided by physicians outside of the plan unless there is an authorized referral. Contact the plans directly regarding their policies on referrals.

For emergency or urgent care, plans are required to pay for care received outside of the network but it may be subject to usual and customary charges. This means the plan may not pay the entire bill and try to negotiate lower fees. However, ultimately the plan must hold you harmless from collection efforts by the provider. *(See the Uniform Benefits definition of emergency care.)*

25. How do I choose a primary physician or pharmacy who's right for me?

If you're not sure a provider holds the same beliefs as you do, call the clinic or pharmacy and ask about your concerns. For example, you may want to ask about the provider's opinion about dispensing a prescription for oral contraceptives.

26. How do I get a listing of the physicians participating in each plan?

Contact the health plan to receive a printed copy directly. Neither ETF nor your employer maintain a current list of this information.

27. Can I change primary physicians within my alternate health plan?

Alternate plans (HMO's and WPS Metro Choice's PPPs) differ in their policies. First contact your health plan to find out when your change will become effective. Then file a *Health Insurance Application/Change* form available from your benefits/payroll/personnel office indicating the effective date of your change as specified by the plan.

28. If my physician or other health care professionals are listed with an alternate health plan, can I continue seeing him or her if I enroll in that alternate health plan?

If you want to continue seeing a particular physician (or psychologist, dentist, optometrist, etc.), contact that physician to see which HMO, if any, he or she is affiliated with and if he or she will be available to you under that HMO. Confirm this with the HMO. Even though your current physician may join an HMO, he or she may not be available as your primary physician just because you join that HMO.

29. What happens if my provider leaves the plan mid-year?

Health care providers appearing in any published health plan provider listing or directory remain available for the entire calendar year except in cases of normal attrition (that is, death, retirement or relocation) or termination due to formal disciplinary action. A participant who is in her second or third trimester of pregnancy may continue to have access to her provider until the completion of post-partum care for herself and the infant.

If a provider contract terminates during the year (excluding normal attrition or formal disciplinary action), the plan is required to pay charges for covered services from these providers on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the member is held harmless. Health plans will individually notify members of terminating providers (prior to the It's Your Choice period) and will allow them an opportunity to select another provider within the plan's network.

Your provider leaving the plan does not give you an opportunity to change plans mid-year.

30. What if I need medical care that my primary physician cannot provide?

As an HMO or SMP participant, you may need to designate a primary physician or clinic. Your primary physician is responsible for managing your health care. Under most

circumstances, he or she may refer you to other medical specialists within the HMO's or SMP's provider network as he or she feels is appropriate. However, referrals outside of the network are strictly regulated. Check with your plan for their referral requirements and procedures.

In case of an injury that may fall under workers compensation, you should utilize only providers in your health plan, in case Workers Compensation denies your claim.

PREMIUM CONTRIBUTION TIERING

31. How are health premium contributions determined ?

Employers determine the amount they will contribute toward the premium under one of the two methods described here.

1. Your employer pays between 50% and 105% of the premium rate of the lowest cost qualified plan in the employer's service area for either single or family coverage for employees who are participants under the Wisconsin Retirement System (WRS).

Your employer may pay as little as 25% of the premium for either single or family coverage for an employee appointed to a position working less than 1044 hours per year and who is a participating employee under the WRS.

2. A Three-Tier health insurance premium option is available. Each health plan is assigned to one of three tiers based on the quality of care and relative efficiency with which it provides benefits. Health plans providing the most cost effective, high-quality care as determined by ETF are assigned to Tier 1, moderately cost-effective plans to Tier 2, and the least cost-effective to Tier 3.

The employee's required contribution to the health insurance premium for coverage is the same dollar amount for all health plans in the same tier, regardless of the total premium.

NOTE: Your employer may contribute any amount toward the premium for retired employees who continue group coverage.

32. Does a health plan with a higher premium or a higher tier offer more benefits?

No, all alternate plans (HMOs and WPS Metro Choice's PPPs) are required to offer the Uniform Benefits. Premium rates and tier placement may vary because of many factors: how efficiently the plan is able to provide services and process

benefit payments; the fees charged in the area in which service is being rendered; the manner in which the health care providers deliver care and are compensated within the service area; and how frequently individuals covered by the plan use the health plan. Also, plans offering optional dental coverage may have slightly higher premiums. The Standard Plan and SMP will continue to offer benefits that differ from Uniform Benefits.

33. How often will premium rates change?

All group premium rates change at the same time — January 1 of each year. The monthly cost of all plans will be announced during the It's Your Choice Enrollment period.

34. How do I pay my portion of the premium?

Active Employees. Premiums are paid in advance. Therefore, initial deductions from your salary probably will occur about one month or more before coverage begins. If the initial deduction cannot occur that far in advance, then double salary deductions may be required initially so as to make premium payments current.

Retired Employees. Premium rates for retired employees are the same as for active employees (except that your premium will decrease when you or a dependent becomes covered by Medicare). The employer may, at its option, pay a portion of the premium. If you are paying your entire premium, it will be deducted from your monthly annuity. If the annuity is not sufficient to allow a premium deduction, you will be billed directly from your insurance carrier.

WARNING: Your coverage will be cancelled if you fail to pay your premium in a timely manner.

If you are retired and have life insurance coverage through the Wisconsin Public Employers' Group Life Insurance Program, you may be eligible to convert the present value of your life insurance to pay health insurance premiums. You must be at least age 67, or age 66 if your employer provides post-retirement life insurance coverage at the 50% level. If you make this election, your life insurance coverage will cease and you will receive credits in a conversion account equal to the present value of your life insurance. The present value ranges from about 44% to 80% of the amount, depending on your age. The life insurance company, Minnesota Life, will pay health insurance premiums on your behalf from your conversion account until the account is exhausted. You will NOT receive any direct cash payment. You may file the election at any time, and it will be effective no earlier than 61 days after the Department receives it. For more information and an election form, contact ETF.

PHARMACY BENEFIT MANAGER (PBM)

35. What is a Pharmacy Benefit Manager (PBM)?

A PBM is a third-party administrator of a prescription drug program that is primarily responsible for processing and paying prescription drug claims. In addition, they typically negotiate discounts and rebates with drug manufacturers, contract with pharmacies, and develop and maintain the drug formulary. The State's PBM uses a fully transparent business model which means they negotiate rebates and discounts on behalf of the State and pass the savings directly back to the State. Currently, the State's PBM is Navitus Health Solutions, LLC (Navitus).

36. What is a formulary, how is it developed, and how will I know if my prescription drug is on it?

A formulary is a list of prescription drugs that are determined to be medically effective and cost-effective. The formulary is developed by a Pharmacy and Therapeutics Committee, which includes a statewide group of physicians and pharmacists. Drugs are evaluated on the basis of effectiveness, side-effects, drug interactions, and then cost. New drugs are reviewed on a continuous basis to make sure the formulary is kept up-to-date and that patient needs are being met.

The complete formulary can be found on Navitus' Web site, www.navitus.com. You may also contact Navitus customer service toll-free at 1-866-333-2757 with questions about the formulary.

37. How does a three-level drug co-payment system work?

Under a three-level prescription drug benefit, you have three different co-payment amounts for covered prescription drugs. By having to pay a lower co-payment for Level 1 and Level 2 drugs you are encouraged to use the preferred formulary drugs. Drugs that are on the formulary at the Level 3 co-payment are not preferred drugs but are still available if you wish to use them and pay the higher co-payment. This gives you more freedom of choice with the drugs that you are prescribed.

Under the three-level prescription drug benefit, it may still be necessary to get a prior authorization before some formulary and non-formulary drugs will be covered. Additionally, only the co-payments for Level 1 and Level 2

(preferred) drugs are applied to your annual out-of-pocket-maximum (OOPM). The co-payment for Level 3 drugs does not count against the OOPM.

38. Will I have to use a different ID card when I go to the pharmacy?

Yes, you will have two identification cards, one from either Navitus or DeanCare Rx (for eligible retirees enrolled in Medicare) for pharmacy benefits. Your member identification number will be different on each card, so it is important that you show the correct card when getting services. When filling prescriptions, you **must** present your Navitus ID card to the pharmacist.

MEDICARE INFORMATION

If you are eligible for Medicare, you must enroll in the hospital (Part A) and medical (Part B) portions of Medicare at the time of your retirement if you continue to participate in the Wisconsin Public Employers (WPE) group health insurance program. Enrollment in the prescription drug portion (Part D) is voluntary. If you are an active employee, these requirements to enroll for Medicare coverage are deferred for you and your dependents until the termination of your WPE employment.

Because all plans that participate in the WPE group health insurance program have coverage options that are coordinated with Medicare, you will remain covered by the plan you have selected even after you enroll in Medicare. Premium rates will decrease if Medicare covers you or a dependent, and you are retired. Medical and prescription drug coverage under the Alternate Plans (like HMO's) does not change. The plan will simply not duplicate benefits paid by Medicare. However, if enrolled in SMP, your coverage will change to the Standard Plan when you enroll in Medicare Parts A and B.

If you do not enroll for all available portions of Medicare (A, B, and D) upon retirement, you may be liable for the portion of your claims that Medicare would have paid on the date Medicare coverage would have become effective.

The **Questions & Answers** below provide additional information about Medicare as it applies to the WPE group health insurance program.

You can also get information about Medicare benefits, eligibility, and enrollment by contacting your local Social Security Administration office or calling 1-800-772-1213. In addition, The

MEDICARE

State Health Insurance Assistance Program (SHIP) has counselors in every State and several Territories that are available to provide free one-on-one help with your Medicare questions or problems. You can reach the Wisconsin SHIP at 1-800-242-1060. You can also find additional information and assistance can be found at <http://dhs.wisconsin.gov/aging/SHIP.htm>. A list of SHIP programs outside of Wisconsin is available at <http://www.medicare.gov/contacts/staticpages/ships.aspx>.

39. What do I need to do when my spouse/domestic partner or I become eligible for Medicare?

IMPORTANT!! When you receive your Medicare card, please send a photocopy to the ETF immediately or your Medicare coordinated coverage may be delayed.

You and your dependents are not required to enroll in Medicare until you, as the subscriber, terminate employment or health insurance coverage as an active employee ceases. At the time of your retirement, you and your dependents that are eligible for Medicare must enroll for the Part A (hospital) portion and Part B (medical) portion of Medicare. When you and/or your dependents enroll in Medicare Parts A and B your group health insurance coverage will be integrated with Medicare and the monthly premium will be reduced.

Enrollment in Medicare Part D (prescription drug coverage) is voluntary and enrollment can also be deferred without penalty, as with Part B, until the subscribers termination.

40. When must I apply for Medicare?

MEDICARE PART A

Most people become eligible for Medicare upon reaching age 65. Individuals who are disabled, as determined by the Social Security Administration (SSA) also become eligible after a 24-month waiting period.

- If you, or your spouse/domestic partner are actively working when you become eligible you may want to consider enrolling in Medicare Part A as it may cover hospital services if your health plan denies them. There is no premium for Medicare Part A.

MEDICARE PART B

The requirement to enroll in Medicare Part B coverage is deferred for active employees and their dependents until the subscriber's termination of their WRS-covered employment, through which active employee health insurance coverage is provided. Likewise, if you or your

insured spouse/domestic partner is insured as an active employee under a non-state group plan, enrollment in Medicare may be deferred until retirement from that job.

If you have terminated employment, or are a surviving dependent, or a continuant and are eligible for coverage under the federal Medicare program, you must immediately enroll in both Part A and Part B of Medicare unless you are otherwise employed and have health insurance coverage through that employment. **If you do not enroll for all available portions of Medicare upon retirement, you may be liable for the portions of your claims that Medicare would have paid beginning on the date Medicare coverage would have become effective.**

For subscribers and their dependents with End Stage Renal Disease (ESRD). You will want to contact your Local Social Security Office, health plan, provider, and Medicare to make sure you to enroll in Medicare Parts A and Part B at the appropriate time. You will want to decide if it would be beneficial to enroll in Part B during your initial or general enrollment opportunities to avoid later delayed Medicare enrollment and potential premium penalties after your 30-month coordination period ends.

MEDICARE PART D

In 2010, retired members enrolled in Medicare who participate in the WPE group health insurance program will be enrolled in DeanCare Rx, a Medicare Part D prescription drug plan (PDP) provided through Dean Health Insurance (DHI). Your monthly health insurance premium includes a portion that applies to the DeanCare Rx coverage.

Before DHI can report your enrollment in Part D to Medicare they need to have your Medicare Health Insurance Claim (HIC) number and Parts A & B effective dates. In most cases, ETF will request this information from you two to three months in advance of your 65th birthday by sending you a “Medicare Eligibility Statement” (ET-4307). ETF will then provide the information to DHI. **If you do not receive the ET-4307 at least one month before your 65th birthday please contact ETF.** The form is also available at ETF’s web site: <http://etf.wi.gov/publications /et4307.pdf>. If you are retired and cover a Medicare eligible, disabled dependent on your plan, please notify ETF and provide your dependent’s Medicare information.

While the coverage under the DeanCare Rx plan is very good and we recommend that you keep it, you can choose to enroll in a Medicare Part D PDP other than DeanCare Rx. (See *Question 43: Does Medicare Part D affect my prescription drug coverage and should I enroll?* and *Question 44: Will my health insurance premium go down if I enroll in Medicare Part D prescription drug plan*).

41. If Medicare coverage is in effect, how do I file Medical, Part B and Pharmacy claims?

If Medicare is the primary insurance, and you are not enrolled in a Medicare Advantage Private Fee-For-Service plan, (MA-PFFS plan), your provider must submit claims to Medicare first. Once Medicare processes the claim(s) Medicare will send you a quarterly Medicare Summary Notice (MSN).

Alternate Plans (WPS Metro Choice's PPP and HMO's(except MA-PFFS plans):

Many of the health plans have an automated procedure after Medicare processes the claim, where the provider then submits it to the health plan for processing. However, some health plans require members to submit a copy of the MSN and, in certain circumstances, a copy of the provider's bill. You should discuss with your provider if they will bill Medicare and your health plan on your behalf. *Contact your health plan for additional information.*

Alternate Medicare Advantage Private Fee-For-Service (MA-PFFS) plans:

An alternate health plan may offer Medicare Coordinated Coverage through a MA-PFFS. When you visit your provider you must show your health plan MA-PFFS card. Your provider will submit your claims directly to the MA-PFFS plan. To request reimbursement for a covered service charge that you paid, send your receipt (noting on it your name and your MA-PFFS member ID) and a copy of your MA-PFFS card to the address on the back of that card.

You must be enrolled in Medicare Parts A and B to be eligible for a health plan's MA-PFFS. You should keep your Medicare card in a safe place, but you should not show it when you receive health care services as the MA-PFFS plan will be primary for your service. (See *Question 42: If I have Medicare as my primary coverage, how are my benefits coordinated?*)

Humana currently offers this type of MA-PFFS plan.

Pharmacy Benefit Manager:

As long as you maintain DeanCare Rx as your Medicare Part D PDP, they will process your claims for both Part D and

the WRAP coverage. However, if you choose to enroll in a PDP other than DeanCare Rx, you will need to file manual claims with DHI for your WRAP benefits. If you are enrolled in a Medicare Part D prescription drug plan your Wisconsin Public Employers' group health insurance pharmacy benefits through Navitus Health Solutions will be considered secondary. Some, but not all, network pharmacies may be able to process the secondary claims electronically. However, you should be prepared to file the secondary claims manually through Navitus. Contact Navitus or visit their web site for more information on filing manual claims.

Medicare Part B pharmacy claims are covered under the WRAP benefit.

42. If I have Medicare as my primary coverage, how are my benefits coordinated?

Since all health plans have coverage options that are coordinated with Medicare, you will remain covered by the plan you selected after you are enrolled in Medicare, even though Medicare is the primary payor of your claims.

Exception: If you are enrolled in SMP, your coverage will be changed to the Standard Plan.

If you are enrolled in an HMO, WPS Metro Choice, or the Standard Plan your health coverage will remain the same as before Medicare coverage became effective. This type of coverage is called a carve-out plan. These plans are designed to supplement, not duplicate, the benefits you receive under Medicare. Because of this coordination with Medicare, your monthly premiums for state health insurance will be less. **Note:** For some benefits under Uniform Benefits, such as durable medical equipment, Medicare Part B and the health plan both have a 20% coinsurance that you are responsible to pay.

Humana will continue to offer its Medicare Coordination Coverage through a Medicare Advantage Private Fee-For-Service plan (MA-PFFS). As Medicare has contracted financial responsibility for medical benefit administration to this MA-PFFS plan, all claims should be submitted to the MA-PFFS plan. You must keep Medicare Parts A and B coverage, but you should put away your Medicare card as you will not need to show it to your providers with this health plan. Members who are direct billed by Humana will receive two bills, that when combined, will add up to the total amount due. Both bills must be paid monthly for coverage to continue.

This MA-PFFS plan offers greater flexibility in provider selection than a traditional HMO for retirees over age 65

and on Medicare. For members under age 65 and not on Medicare, you must comply with the health plan's network requirements.

If you are enrolled in MA-PFFS plan, have Medicare Part A and B, and are no longer an active employee, your benefits will be modeled on Uniform Benefits, and include those of original Medicare. You have the freedom to choose providers however, prior to seeking services we recommend you ask your provider if he/she

- Participates with Medicare
- Accepts Medicare's payments
- And accepts the health plan's MA-PFFS plan administration (not an HMO)

If your provider does not, contact the MA-PFFS plan for further assistance and you may be subject to out-of-pocket costs.

MEDICARE PART D INFORMATION

43. Does Medicare Part D affect my prescription drug coverage and should I enroll?

A Medicare Part D prescription drug plan (PDP) provides primary coverage of prescription benefits through Medicare. While enrollment in a PDP is voluntary, if you do not enroll when you are first eligible and do not have what Medicare considers creditable coverage, you may have to pay a penalty in the form of a higher PDP premium once you do enroll.

Under the WPE group health insurance program, after you become eligible for Medicare Part D your prescription drug benefits will no longer be provided through Navitus, and the following will happen:

- You will be enrolled in the DeanCare Rx Medicare Part D PDP. **Your health insurance premium already includes the DeanCare Rx PDP coverage through DHI.** While we encourage you to maintain the DeanCare Rx coverage, you do have the option of enrolling in another PDP of your choice.
- You will also be automatically enrolled for secondary coverage provided by Dean Health Insurance (DHI) through what is called a WRAP product. This provides you with additional benefits that "wrap around" the benefits available from your PDP. The WRAP benefit covers drug costs that would normally be experienced during the coverage gap ("donut-hole"). **Your health insurance premium already includes the WRAP coverage through DHI.**

44. Will my health insurance premium go down if I enroll in a Medicare Part D prescription drug plan?

If you maintain your Medicare Part D coverage through DeanCare Rx your health insurance premium will not be reduced. A portion of the premium pays for the DeanCare Rx coverage.

If you decide to enroll in a PDP other than DeanCare Rx, you will receive a refund of the portion of the premium that specifically applies to the DeanCare Rx PDP. Refunds are issued semi-annually. If you do enroll in another PDP you will still be covered by the WRAP benefit. WRAP coverage cannot be dropped and you will not receive a refund of the associated premiums.

CHANGING HEALTH PLANS

45. Can I change from one plan to another during the year?

Yes, but only if you, the subscriber file an application within **30 days** for the following events with coverage effective on the first day of the month on or following receipt of the application:

- Move from your plan's service area (for example, out of the county) for a period of at least **3 months**. Your new coverage will be effective subsequent to your move. You may again change plans when you return for **3 months** by submitting another application within **30 days** after your return. (See *Questions 48: What if I have a temporary or permanent move from the service area?*)
- You or a dependent incurs a claim that would meet or exceed the lifetime maximum benefit amount on all benefits. An application must be filed during the **30 day** period after a claim is denied due to the operation of the lifetime limit on all benefits. (If you learn that you are nearing your health plans lifetime maximum, you should consider changing health plans during the next It's Your Choice enrollment period to avoid out-of-pocket costs.)
- You involuntarily lose other coverage or lose the employer contribution for it.
- You add one or more dependants due to marriage, domestic partnership, birth, adoption, or placement for adoption.

or

- You may change to the Standard Plan at any time by canceling your existing coverage and submitting an application for the Standard Plan. However, there will be a **180 day** waiting period for any pre-existing conditions (except pregnancy) for all participants. There is no waiting period for any children born after the effective date of the Standard Plan coverage. Pre-existing condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date.

Otherwise, you can only change health plans without restriction during each It's Your Choice Enrollment period.

46. If I change plans, what happens to any benefit maximums that may apply to services I've received?

When you change plans for any reason (for example, It's Your Choice or a move from a plan's service area), any annual health insurance benefit maximums under Uniform Benefits will start over at \$0 with your new plan, even if you change plans mid-year such as durable medical equipment. However, orthodontia benefit maximums typically carry over from one plan to the next. Orthodontia is an optional and not part of the Uniform Benefits medical plan.

47. If I leave a plan and later re-enroll in that plan, does my lifetime benefit maximum start over?

The lifetime benefit maximum is per participant per plan. When you change from one health plan to another, your lifetime maximum with the new plan will start over at \$0. If you later return to a plan under which you were previously covered, the plan may count any benefits paid during all periods of coverage toward the lifetime benefit maximum for that plan. The only exception is if you are covered by a plan under the Wisconsin Public Employers' program and then under the Wisconsin Public Employers' Group Health Insurance program, or vice versa. In that situation, the lifetime benefit maximums accumulate separately, as these are separate insurance programs.

48. What if I have a temporary or permanent move from the service area?

A subscriber who moves out of a service area, (for example, out of the county) either permanently, or temporarily for **3 months** or more will be permitted to enroll in the

Standard Plan, or an available alternate plan, provided an application for such plan is submitted within **30 days** after relocation. You will be required to document the fact that your application is being submitted due to a change of residence out of a service area.

It is important that you submit your application to change coverage as soon as possible and no later than **30 days** after the change of residence to maintain coverage for non-emergency services. The change in plans will be effective on the first day of the month on or after your application is received by your employer but not prior to the date of your move. If your application is received after the **30 day** deadline, you are only eligible for the Standard Plan with a **180 day** waiting period for pre-existing conditions (except pregnancy). *(See Question 31: How are my health premium contributions determined?)*

If your relocation is temporary, you may again change plans by submitting an application within **30 days** after your return. The change will be effective on the first of the month on or after your application is received by your employer or by ETF if you have terminated employment.

49. What if I change plans but am hospitalized before the date the new coverage becomes effective and am confined as an inpatient on the date the change occurs (such as January 1)?

If you are confined as an inpatient (in a hospital, a skilled nursing facility, or in some cases an Alcohol and Other Drug Abuse (AODA) residential center) or require 24 hours home care on the effective date of coverage with the new plan, you will begin to receive benefits from your new plan unless the facility you are confined in is not in your new plan's network. If you are confined in such a facility, your claims will continue to be processed by your prior plan as provided by contract until that confinement ends and you are discharged from the non-network hospital or other facility, 12 months have passed, or the contract maximum is reached. If you are transferred or discharged to another facility for continued treatment of the same or related condition, it is considered one confinement.

In all other instances, the new plan assumes liability immediately on the effective date of your coverage, such as January 1.

CANCELLATION OR TERMINATION OF HEALTH COVERAGE

50. How do I cancel coverage and how might this impact me if I later want to re-enroll?

Voluntary cancellation (or switching from family to single coverage which is deemed voluntary cancellation for all insured dependents) requires written notification to the employer (annuitants contact ETF) denoting a cancellation of coverage. Be aware that voluntary cancellation of coverage does not provide an opportunity to continue coverage for previously covered dependents as described in section *CONTINUATION OF HEALTH COVERAGE*.

Cancellation affects both medical and prescription drug coverage.

No REFUNDS are made for premiums paid in advance unless your employer (or ETF if you are no longer an employee of a participating local employer) receives your written request on or before the last day of the month preceding the month for which you request the refund. Under no circumstances are partial month's premiums refunded. Once coverage terminates, you will be responsible for any claims inadvertently paid beyond your coverage effective dates.

Once an annuitant's coverage is cancelled, neither you nor your surviving dependents may re-enroll in this program. Another insurance opportunity may exist under the Local Annuitant Health Plan (LAHP). Contact ETF for more information.

51. When can an employee's health insurance coverage be terminated?

Your coverage can only be terminated because:

- Premiums are not paid by the due date. Coverage is also waived (known as "constructive waiver") when the employee portion of the premium is not deducted for twelve consecutive months.
- Coverage is voluntarily cancelled.
- Eligibility for coverage ceases (for example, terminate employment).
- Death of the subscriber.
- Fraud is committed in obtaining benefits or inability to establish a physician/patient relationship. Termination of coverage for this reason requires Group Insurance Board approval.

Contact your benefits/payroll/personnel office or ETF for the date coverage will end.

52. What if my employer's participation ends under the Wisconsin Public Employers' Group Health Insurance Program?

When your employer's participation ends in this program, coverage will cease for all participants. This includes retirees and those who have continuation coverage. If the employer obtains group health insurance from another carrier, ask the employer if the new carrier will provide coverage for retirees and continuants.

When the employer terminates participation, you will not be eligible for continuation or conversion of health coverage.

CONTINUATION OF HEALTH COVERAGE

53. Who is eligible for continuation?

Your COBRA continuation rights are described in the State and Federal Notification Section of this guide. **Both you and your dependents should take the time to read that section carefully.** This section provides additional information about continuation coverage.

You do not have to provide evidence of insurability to enroll in continuation coverage. However, coverage is limited to the plan you had as an active employee or covered dependent. (For example, if you change plans January 1 and your dependent loses eligibility December 31, that dependent would be eligible for COBRA from the plan you were enrolled in on December 31. An exception is made when the participant resides in a county that does not include a primary physician for the subscriber's plan at the time continuation is elected. In that case, the participant may elect a different plan that is offered in the county where the participant resides.) You may select another plan during the It's Your Choice Enrollment period or if you move from the service area. If family coverage is not elected when continuation is first offered, each dependent may independently elect single continuation coverage. A family of two may select two single contracts at a lower cost than the premium for a family contract. The plan will bill you directly.

There can be no lapse in coverage so multiple premiums may be required.

A second qualifying event while on continuation will not serve to extend your period of continuation. Coverage will be limited to the original 36 months. At the end of the

continuation period you will be allowed to enroll in an individual conversion health plan.

54. Does my coverage change under continuation?

No, continuation coverage is identical to the active employee coverage. In most cases, you are eligible to maintain continuation coverage for **36 months** from the month of the qualifying event and are allowed to change plans during the annual It's Your Choice Enrollment period or if the subscriber moves from the service area. However, your continuation coverage may be cut short for any of the following reasons:

- The premium for your continuation coverage is not paid when due.
- You or a covered family member become covered under another group health plan that does not have a pre-existing conditions clause which applies to you or your covered family member.
- You were divorced or your domestic partnership terminated from an insured employee and subsequently remarry or establish a new domestic partnership and are insured through your new spouse's group health plan.

55. Will my premium change under continuation?

It may change as you will pay the total premium amount which includes both the employee and employer share. Contact your benefits/payroll/personnel office to obtain the total amount.

56. How do I cancel continuation coverage?

To cancel continuation coverage, notify ETF in writing. Include your name, Social Security number, date of birth, and address. ETF will forward your request to the health plan. Your coverage will be cancelled at the end of the month in which ETF receives the request to cancel coverage.

57. When is conversion coverage available?

As required by law, you are eligible to apply for conversion coverage when group continuation coverage terminates. Contact the plan directly to make application for conversion coverage. Conversion coverage is available without providing evidence of insurability, and with no waiting period for pre-existing conditions, provided Wisconsin Public Employers' group coverage has been in effect for at least **three months** prior to termination.

If the health plan automatically bills you for conversion coverage that you do not want, simply do not pay the premium for the coverage. The coverage offered will be the conversion contract (not the Wisconsin Public Employers' plan) available at the time, subject to the rates and regulations then in effect. The coverage and premium amount may vary greatly from plan to plan.

If you reside outside of the HMO service area at the time you apply for conversion coverage, you may only be eligible for an out-of-area conversion policy through another insurance carrier. The benefits and rates of the out-of-area conversion plan are subject to the regulations in effect in the state in which you reside.

The conversion privilege is also available to dependents when they cease to be eligible under the subscriber's family contract. Request for conversion must be received by the plan within **30 days** after termination of group coverage. If you have questions regarding conversion, write or call the plan in which you are enrolled.

58. How is my continuation coverage affected if I move from the service area?

If you move out of the service area (either permanently, or temporarily for 3 months or more) you are eligible to change plans. (See *Question 48: What if I have a temporary or permanent move from the service area?*).

Your application to change plans must be postmarked within 30 days after your move. Because you are on continuation coverage, call the Employer Communication Center at (608) 264-7900 to obtain a *Health Insurance Application/Change* form (ET-2301). Complete and submit the application to the Department of Employee Trust Funds, P. O. Box 7931, Madison, WI 53707-7931.

CERTIFICATE OF COVERAGE

This is your description of benefits that are administered by the Alternate Plans. Keep this for your reference.

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



Uniform Benefits

The Group Insurance Board adopted a uniform medical insurance benefits package for alternate 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:

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

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 BENEFITS

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

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

NOTE: *Employees and retirees of participating local governments that have selected the deductible option have an up-front deductible of \$500 per individual / \$1,000 per family, per calendar year. Benefits administered by the PBM do not apply toward the deductible. After the deductible is met, Uniform Benefits are administered as outlined below.*

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

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” booklet.

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

- Policy Deductible: NONE
- Policy Coinsurance: 100% of charges, except as described below
- Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: \$2,000,000 per Participant
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: NONE
- Outpatient Physical, Speech and Occupational Therapy Maximum: Covered up to 50 visits 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.
- Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies
Coinsurance: Payable at 80%. Out-of-pocket expense will not exceed \$500.00 annually per Participant.
- Hearing Aids: One hearing aid per ear no more than once every three years payable at 80%, up to a maximum payment of \$1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment. As required by Wis. Stat. §632.895 (16), hearing aids for Participants under 18 years of age are payable at 100% and the \$1,000 limit does not apply.
- Cochlear Implants: Device, surgery for implantation of the device, and follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan, payable at 80%. Hospital charges for the surgery are covered at 100%. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable at 100%.

SCHEDULE OF BENEFITS

- Home Care Benefits Maximum: 50 visits per Participant per calendar year. Fifty 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 6 months or less, as authorized by the Health Plan.
- Transplants: Limited to transplants listed in Benefits and Services section, subject to a lifetime benefit of \$1,000,000 for transplants, including Preoperative and Postoperative Care.
- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.
- Mental Health/Alcohol/Drug Abuse Services*:
 - Outpatient Services: \$1,800 maximum per Participant per calendar year
 - Transitional Services: \$2,700 maximum per Participant per calendar year
 - Inpatient Services: 30 days or \$6,300, whichever is less, per Participant per calendar year
 - Maximum Benefit: The maximum benefit for inpatient, outpatient and transitional services is \$7,000 per Participant per calendar year.

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

***Note:** *Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended pursuant to the Federal Mental Health Parity Act.*

- Autism Spectrum Disorders: Benefits payable up to \$50,000 per Participant per calendar year for intensive-level and up to \$25,000 per year for nonintensive-level services.
- 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: The maximum benefit for diagnostic procedures and non-surgical treatment is \$1,250 per Participant per calendar year. Intraoral splints are subject to the Durable Medical Equipment Coinsurance (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.
- Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services section. However, each Health Plan may choose to provide a dental plan to all of its members.
- Hospital Emergency Room Copayment: \$60 per visit; waived if admitted as an inpatient directly from the emergency room. (An inpatient stay is generally 24 hours or longer.)

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

- Prescription Drugs and Insulin:

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

Annual Out-of-Pocket Maximum (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:
- No annual out-of-pocket maximum for Participants enrolled in the Standard Plan or State Maintenance Plan (SMP)

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

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

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

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

II. DEFINITIONS

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

- **BED AND BOARD:** Means all Usual and Customary Hospital charges for: (a) Room and meals; and (b) all general care needed by registered bed patients.
- **BENEFIT PERIOD:** Means the total duration of Confinements that are separated from each other by less than 60 days.
- **BRAND NAME DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and Generic Drug classifications.
- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.
- **CONFINEMENT/CONFINED:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA residential center, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of Your physician; and discharge therefrom, or (b) the time spent receiving Emergency Care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement. Charges for Hospital or other institutional Confinements are incurred on the date of admission. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.
- **CONGENITAL:** Means a condition which exists at birth.
- **COINSURANCE:** A specified percentage of the charges that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **COPAYMENT:** A specified dollar amount that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **CUSTODIAL CARE:** Provision of room and board, nursing care, personal care or other care designed to assist an

individual who, in the opinion of a Plan Provider, has reached the maximum level of recovery. Custodial Care is provided to Participants who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered Custodial Care if the Participant is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the Plan Provider, that the medical or surgical treatment will enable that person to live outside an institution. Custodial Care also includes rest cures, respite care, and home care provided by family members.

- **DEPENDENT:** Means the Subscriber's:
 - Spouse.
 - Domestic Partner.
 - Unmarried child.
 - Legal ward who becomes a legal ward of the Subscriber prior to age 19, but not a temporary ward.
 - Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
 - Stepchild or child of the Domestic Partner.
 - Grandchild if the parent is a Dependent child. The Dependent grandchild will be covered until the end of the month in which the Dependent child turns age 18.

A Dependent child must be dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed.

A child born outside of marriage becomes a Dependent of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Children and Families or equivalent if the birth was outside of Wisconsin. The Effective Date of coverage will be the date of birth if a statement of paternity or a court order is filed within 60 days of the birth.

A spouse and a stepchild cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment. 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.

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

1. A dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible Dependent, regardless of age, so long as the child remains so disabled if he or she is otherwise eligible (that is, the child meets the support tests as a Dependent for federal income tax purposes and is not married). The Health Plan will monitor mental or physical disability at least annually, terminating coverage prospectively upon determining the Dependent is no longer so disabled, and will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.
2. As required by Wis. Stat. § 632.885, a Dependent includes a child that is not married and is not eligible for coverage under a group health insurance plan that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a Dependent under this program. The child ceases to be a Dependent at the end of the month in which he or she:
 - turns 27 years of age, or
 - is no longer 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.
3. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.
4. Any Dependent eligible for benefits who is not listed on an application for coverage 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 of Employee Trust Funds and shown on the records of the Health Plan and/or PBM, on which the Participant becomes enrolled and entitled to the benefits specified in the contract.
- **ELIGIBLE EMPLOYEE:** As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.
- **EMERGENCY:** Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson to reasonably conclude that a lack of medical attention will likely result in any of the following:

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1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
2. Serious impairment to the Participant's bodily functions.
3. Serious dysfunction of one or more of the Participant's body organs or parts.

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

- **EXPENSE INCURRED:** Means an expense at or after the time the service or supply is actually provided - not before.
- **EXPERIMENTAL:** The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a Participant's Illness or Injury that, as determined by the Health Plan and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that Illness or Injury for a Participant's Illness or Injury. The criteria that the Health Plan and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that Illness or Injury by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the Illness or Injury have been exhausted by the Participant; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

- **FORMULARY:** A list of prescription drugs, established by a committee of physicians and pharmacists, which are determined to be medically- and cost-effective. The PBM may require Prior Authorization for certain Formulary and non-Formulary drugs before coverage applies.
- **GENERIC DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.
- **GENERIC EQUIVALENT:** Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.
- **GRIEVANCE:** Means a written complaint filed with the Health Plan and/or PBM concerning some aspect of the Health Plan and/or PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.
- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during this calendar year.
- **HOSPICE CARE:** Means services provided to a Participant whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the Participant as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care Provider approved by the Health Plan.
- **HOSPITAL:** Means an institution that:
 1. (a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, Injury and Illness; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses; or
 2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare Provider; and (c) is accredited as a Hospital by the Joint Commission of Accreditation of Hospitals.The term Hospital does not mean an institution that is chiefly:
(a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal Hospital.

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- **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.
- **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.
- **MEDICARE:** Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
 - **MEDICAID:** Means a program instituted pursuant to Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
 - **MISCELLANEOUS HOSPITAL EXPENSE:** Means Usual and Customary Hospital ancillary charges, other than Bed and Board, made on account of the care necessary for an Illness or other condition requiring inpatient or outpatient hospitalization for which Plan Benefits are available under this Health Plan.
 - **NATURAL TOOTH:** Means a tooth that would not have required restoration in the absence of a Participant's trauma or Injury, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.
 - **NON-EXPERIMENTAL:** Means: (a) any discrete and identifiable technology, regimen or modality regularly and customarily used to diagnose or treat Illness; and (b) for which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective.
 - **NON-PARTICIPATING PHARMACY:** Means a pharmacy who does not have a signed agreement and is not listed on the most current listing of the PBM's provider directory of Participating Pharmacies.
 - **NON-PLAN PROVIDER:** Means a Provider who does not have a signed participating Provider agreement and is not listed on the most current edition of the Health Plan's professional directory of Plan Providers. Care from a Non-Plan Provider requires prior-authorization from the Health Plan unless it is an Emergency or Urgent Care.
 - **NUTRITIONAL COUNSELING:** This counseling consists of the following services:

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1. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician
 2. Re-assessment and intervention (individual and group)
 3. Diabetes outpatient self-management training services (individual and group sessions)
 4. Dietitian visit
- **OUT-OF-AREA SERVICE:** Means any services provided to Participants outside the Plan Service Area.
 - **PARTICIPANT:** The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.
 - **PARTICIPATING PHARMACY:** A pharmacy who has agreed in writing to provide the services that are administered by the PBM and covered under the policy to Participants. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a Participant. The PBM agrees to give You lists of Participating Pharmacies.
 - **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.
 - **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.
 - **PLAN DEPENDENT:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.
 - **PLAN PROVIDER:** A Provider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Participants. The Provider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a Participant. The Health Plan agrees to give You lists of affiliated Providers. Some Providers require

Prior Authorization by the Health Plan in advance of the services being provided.

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

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

- **PRIOR AUTHORIZATION:** Means obtaining approval from Your Health Plan before obtaining the services. Unless otherwise indicated by Your Health Plan, Prior Authorization is required for care from any Non-Plan Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan and are described in the Health Plan Descriptions section, of the *"It's Your Choice: Decision Guide"* booklet. Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.
- **PROVIDER:** Means a doctor, Hospital, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Plan Benefits.

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- **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"* booklet. The authorization from the Health Plan will state: a) the type or extent of treatment authorized; and b) the number of Prior Authorized visits and the period of time during which the authorization is valid. In most cases, it is the Participant's responsibility to ensure a Referral, when required, is approved by the Health Plan before services are rendered.
- **SCHEDULE OF BENEFITS:** The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the Health Plan You elected.
- **SELF-ADMINISTERED INJECTABLE:** Means an injectable that is administered subcutaneously and can be safely self-administered by the Participant and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.
- **SKILLED CARE:** Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving Skilled Care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, "Skilled Care" is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, 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 require special storage and handling and as a result, are more costly and usually not available from all Participating Pharmacies.
- **STATE:** Means the State of Wisconsin as the policyholder.
- **SUBSCRIBER:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.
- **URGENT CARE:** Means care for an accident or illness which is needed sooner than a routine doctor's visit. If the accident or injury occurs when the Participant is out of the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider. Urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.
- **USUAL AND CUSTOMARY CHARGE:** An amount for a treatment, service or supply provided by a Non-Plan Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related charges) prior to receiving services. Health Plan approved Referrals to Non-Plan Providers are not subject to Usual and Customary Charges. However, Emergency or urgent services from a Non-Plan Provider may be subject to Usual and Customary

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

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

III. BENEFITS AND SERVICES

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

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

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

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

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

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

A. MEDICAL/SURGICAL SERVICES

1. Emergency Care

- a. Medical care for an Emergency, as defined in section II. Refer to the Schedule of Benefits for information on the emergency room Copayment.

- b. Plan Hospital emergency rooms should be used whenever possible. Should You be unable to reach Your Plan Provider, go to the nearest appropriate medical facility. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You are receiving Emergency care. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan. In addition to the emergency room Copayment, this out-of-plan Emergency care may be subject to Usual and Customary Charges.
- c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.
- d. Emergency services include reasonable accommodations for repair of Durable Medical Equipment as Medically Necessary.
- e. Some examples of Emergencies are:
 - 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.

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 daughter who is covered under this plan as a Participant. However, this does not extend coverage to

the newborn who is not otherwise eligible (limited to if the Dependent daughter is age 18 or over at the time of birth). In accordance with the federal Newborns' and Mother's 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, 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. Medically Necessary travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the Participant by the Health Plan. It does not apply to travel required for work. (See Exclusion A., 2., e.)
- e. Injectable and infusible medications, except for Self-Administered Injectable medications.
- f. Nutritional Counseling provided by a participating registered dietician or Plan Provider.
- g. A second opinion from a Plan Provider or when Prior Authorized by the Health Plan.

6. Anesthesia Services

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

7. Radiation Therapy 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.

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.

11. Outpatient Physical, Speech and Occupation Therapy

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

12. Home Care Benefits

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

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

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

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

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

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

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

13. Hospice Care

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

14. Phase II Cardiac Rehabilitation

Services must be approved by the Health Plan and provided in an outpatient department of a Hospital, in a medical center or clinic program. This benefit may be appropriate only for Participants with a recent history of: (a) a heart attack (myocardial infarction); (b) coronary bypass surgery; (c) onset of angina pectoris; (d) heart valve surgery; (e)

onset of decubital angina; (f) onset of unstable angina; (g) percutaneous transluminal angioplasty; or (h) heart transplant. Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under this contract.

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

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

16. Oral Surgery

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

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

- j. Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related Medically Necessary guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.
- k. Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

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

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

17. Treatment of Temporomandibular Disorders

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

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

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

18. Transplants

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

Postoperative Care, are applied to the \$1,000,000 maximum lifetime benefit for transplants.

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

19. Kidney Disease Treatment

Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum- 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 the treatment of breast cancer 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 Prosthesis (See DME in Section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas;
- o Breast implants, which are not subject to coinsurance.

22. Smoking Cessation

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

B. INSTITUTIONAL SERVICES

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

1. Inpatient Care

- a. Hospitals and Specialty Hospitals: Covered for semi-private room, ward or intensive care unit and Medically Necessary Miscellaneous Hospital Expenses, including prescription drugs administered during the

Confinement. A private room is payable only if Medically Necessary for isolation purposes as determined by the Health Plan.

- b. Licensed Skilled Nursing Facility: Must be admitted within twenty-four (24) hours of discharge from a general Hospital for continued treatment of the same condition. Care must be Skilled. Custodial Care is excluded. Benefits limited to the number of days specified in the Schedule of Benefits. Benefits include prescription drugs administered during the Confinement. Confinement in a swing bed in a Hospital is considered the same as a Skilled Nursing Facility Confinement.
- c. Hospital and Ambulatory Surgery Center Charges and related Anesthetics for Dental Care: Covered if services are provided to a Participant who is under five years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2. Outpatient Care

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

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

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

Surgical Care: Covered.

C. OTHER MEDICAL SERVICES

1. Mental Health Services/Alcohol and Drug Abuse

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

a. Outpatient Services

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

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

b. Transitional Services

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

c. Inpatient Services

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

d. Other

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

2. Durable Diabetic Equipment and Related Supplies

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

- Automated injection devices.
- Continuing glucose monitoring devices.

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

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

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

3. Medical Supplies and Durable Medical Equipment

When prescribed by a Plan Provider for treatment of a diagnosed Illness or Injury and purchased from a Plan Provider, Medical Supplies and Durable Medical Equipment will be covered **subject to 20% Coinsurance as outlined in the Schedule of Benefits.**

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

- Initial acquisition of artificial limbs or eyes or as needed for growth and development.
- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- Rental or, at the option of the Health Plan, purchase of equipment 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.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.
- Cochlear implants, which includes the device, surgery for implantation of the device, and follow-up sessions to train on use of the device, covered at 80% as determined Medically Necessary by the Health Plan. Hospital charges for the surgery are covered at 100%. The annual out-of-pocket maximum for Durable Medical Equipment does not apply to this benefit. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable at 100%.
- One hearing aid, per ear, no more than once every three years, as determined by the Health Plan to be Medically Necessary, covered at 80% up to a maximum payment of \$1,000 per hearing aid. The maximum payment applies to all services directly related to the hearing

aid, for example, an ear mold. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment. As required by Wis. Stat. §632.895 (16), hearing aids for Participants under 18 years of age are payable at 100% and the \$1,000 limit does not apply.

- 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 20% Coinsurance as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids, the out-of-pocket costs will apply to the annual out-of-pocket maximum for Durable Medical Equipment.

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

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

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

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

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

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

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, paraprofessional working under the supervision of any of those three types of providers, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Benefits are payable up to \$50,000 per year for intensive-level and up to \$25,000 per calendar year for nonintensive-level services. 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 maximum applies to Participants' Copayments for Level 1 and Level 2 Formulary prescription drugs as described on the Schedule of Benefits. When any Participant meets the annual out-of-pocket maximum, when applicable, as described on the Schedule of Benefits, that Participant's Level 1 and Level 2 Formulary prescription drugs will be paid in full for the rest of the calendar year. Further, if participating family members combined have paid in a year the family annual out-of-pocket maximum as described in the Schedule of Benefits, even if no one Participant has met his or her individual annual out-of-pocket maximum, all family members will have satisfied the annual out-of-pocket maximum for that calendar year. The Participant's cost for Level 3 drugs will not be applied to the annual out-of-pocket maximum. If the cost of a prescription drug is less than the applicable Copayment, the Participant will pay only the

actual cost and that amount will be applied to the annual out-of-pocket maximum for Level 1 and Level 2 Formulary prescription drugs.

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

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

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

Prescription drugs will be dispensed as follows:

- a. In maximum quantities not to exceed a 30 consecutive day supply per Copayment.
- b. The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns).
- c. Single packaged items are limited to 2 items per Copayment or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.
- d. Oral contraceptives are not subject to the 30-day supply and will be dispensed at one Copayment per package or a 28-day supply, whichever is less.
- e. Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the Formulary. These require a prescription from a physician and must be filled at a Participating Pharmacy. Only one 30-day supply of medication may be obtained at a time and is subject

to the prescription drug Copayment and annual out-of-pocket maximum. Coverage is limited to a maximum of one consecutive three-month course of pharmacotherapy per calendar year.

- f. Prior Authorization from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring Prior Authorization is available from the PBM.
- g. Cost-effective Generic Equivalents will be dispensed unless the Plan Provider specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the Copayment specified in the Formulary.
- h. Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Formulary prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two Copayments will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. Self-Administered Injectables and narcotics are among those for which a 90-day supply is not available.
- i. Tablet Splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 Formulary drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply (15 tablets – 30-day supply). Participants who use tablet splitting will pay half the normal Copayment amount.
- j. Generic sampling is available to encourage the use of Level 1 Formulary medications, whereby the PBM may waive the Copayment of a Level 1 Formulary prescription drug on the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.
- k. The PBM reserves the right to designate certain over the counter drugs on the Formulary.
- l. Specialty Medications and Self-Administered Injectables when obtained by prescription and which can safely be administered by the Participant, must be obtained from a PBM Participating Pharmacy or in some cases, the PBM may need to limit availability to specific pharmacies.

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

2. Insulin, Disposable Diabetic Supplies, Glucometers

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

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

3. Other Devices and Supplies

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

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

IV. EXCLUSIONS AND LIMITATIONS

A. EXCLUSIONS

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

1. Surgical Services

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

2. Medical Services

- a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation

in athletics, 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 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 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.

8. Hospital Inpatient Services

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

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

9. Mental Health Services/Alcohol and Drug Abuse

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

10. Durable Medical or Diabetic Equipment and Supplies

- a. All Durable Medical Equipment purchases or rentals unless Prior Authorized as required by the Health Plan.
- b. Repairs and replacement of Durable Medical Equipment/supplies unless authorized by the Health Plan.
- c. Medical Supplies and Durable Medical Equipment for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for an hearing impairment); and self-help devices not Medically Necessary, as determined by the Health Plan, including, but not limited to, shower chairs and reaches.
- d. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as Prior Authorized by the Health Plan.
- e. Equipment, models or devices that have features over and above that which are Medically Necessary for the Participant will be limited to the standard model as determined by the Health Plan. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the

Participant's condition nor is the existing equipment, models or devices in need of repair or replacement.

- f. 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).

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.
- 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 Participant (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.
- j. Maintenance Care.
- k. Care provided to assist with activities of daily living (ADL).
- l. Personal comfort or convenience items such as in-Hospital television, telephone, private room, housekeeping, shopping, and homemaker services, and meal preparation services as part of home health care.
- m. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.
- n. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.
- o. Expenses incurred prior to the coverage Effective Date in the Health Plan and/or PBM, or services received after the Health Plan and/or PBM coverage or eligibility terminates. Except when a Participant's coverage terminates because of Subscriber cancellation or nonpayment of premium, benefits shall continue to the Participant if he or she is Confined as an inpatient on the coverage termination date but only until the attending physician determines that Confinement is no longer Medically Necessary; the contract maximum is reached; the end of 12 months after the date of termination; or Confinement ceases, whichever occurs first. If the termination is a result of a Subscriber changing Health Plans during a prescribed enrollment period as determined by the Board, benefits after the effective date with the succeeding Health Plan will be the responsibility of the succeeding Health Plan unless the facility in which the Participant is Confined is not part of the succeeding Health Plan's network. In this instance, the liability will remain with the previous insurer.
- p. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye following cataract surgery.

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

- y. Any diet control program, treatment, or supply for weight reduction.
- z. Food or food supplements except when provided during a covered outpatient or inpatient Confinement.
- aa. 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.
- ab. Services related to an Injury that was self-inflicted for the purpose of receiving Health Plan and/or PBM Benefits.
- ac. 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.
- ad. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits and Services section.
- ae. 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.
- af. Sexual counseling services related to infertility and sexual transformation.
- ag. Services that a child's school is legally obligated to provide, whether or not the school actually provides them and whether or not You choose to use those services.

B. LIMITATIONS

1. Copayments or Coinsurance are required for, and/or limitations apply to, the following services: Outpatient Services/Mental Health Services/Alcohol and Drug Abuse, Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.

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2. Benefits are limited for the following services: Replacement of Natural Teeth because of accidental Injury, Oral Surgery, Hospital Inpatient, licensed Skilled Nursing Facility, Physical, Speech and Occupational Therapy, Home Care Benefits, Transplants, Hearing Aids, and Orthoptics.
3. Use of Non-Plan Providers and Hospitals requires prior written approval by the Participant's Primary Care Provider and the Health Plan to determine medical appropriateness and whether services can be provided by Plan Providers.
4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, Participants may receive covered services from Non-Plan Providers and/or Non- Participating Pharmacies.
5. Circumstances Beyond the Health Plan's and/or PBM's Control: If, due to circumstances not reasonably within the control of the Health Plan and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the Health Plan and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the Health Plan, Plan Providers and/or PBM will use their best efforts to provide services and other benefits covered hereunder. In this case, Participants may receive covered services from Non-Plan Providers and/or Non- Participating Pharmacies.
6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a Plan Provider for determining the need for correction.
7. Outpatient Physical, Occupational, Speech and Rehabilitation Therapy: These therapies are benefits only for treatment of those conditions which, in the judgment of the attending physicians, are expected to yield significant patient improvement within two months after the beginning of treatment.

8. Lifetime policy maximum for transplant benefits: \$1,000,000.
Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.
9. Lifetime maximum benefits under this policy for charges paid by the Health Plan and PBM: \$2,000,000 (includes transplant benefits) per Health Plan.

V. COORDINATION OF BENEFITS AND SERVICES

A. APPLICABILITY

1. This Coordination of Benefits (“COB”) provision applies to This Plan when a Participant has health care coverage under more than one Plan at the same time. “Plan” and “This Plan” are defined below.
2. If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
 - a. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
 - b. may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in section D below, Effect on the Benefits of This Plan.

B. DEFINITIONS

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

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

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

2. “Claim Determination Period” means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any

part of a year before the date this COB provision or a similar provision takes effect.

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

- a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under a. or b. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

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

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

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

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

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

C. ORDER OF BENEFIT DETERMINATION RULES

1. General

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

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

2. Rules

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

- a. Non-Dependent/Dependent

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

- b. Dependent Child/Parents Not Separated or Divorced

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

- 1) the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but
- 2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

- c. Dependent Child/Separated or Divorced Parents

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

- 1) first, the Plan of the parent with custody of the child;
- 2) then, the Plan of the spouse of the parent with the custody of the child; and
- 3) finally, the Plan of the parent not having custody of the child.

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

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

d. Active/Inactive Employee

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

e. Continuation Coverage

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

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

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

f. Longer/Shorter Length of Coverage

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

D. Effect On The Benefits Of The Plan

1. When This Section Applies

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

2. Reduction in This Plan's Benefits

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

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

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

E. Right To Receive And Release Needed Information

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

F. Facility Of Payment

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

G. Right Of Recovery

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

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

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

VI. MISCELLANEOUS PROVISIONS

A. RIGHT TO OBTAIN AND PROVIDE INFORMATION

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

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

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

B. PHYSICAL EXAMINATION

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

C. CASE MANAGEMENT/ALTERNATE TREATMENT

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

D. DISENROLLMENT

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

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

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

In situations where a Participant has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate Primary Care Provider, disenrollment efforts may be initiated

by the Health Plan or the Board. The Subscriber's disenrollment is effective the first of the month following completion of the Grievance process and approval of the Board. Coverage may be transferred to the Standard Plan only, with options to enroll in alternate Health Plans during subsequent dual-choice enrollment periods. Reenrollment in the Health Plan is available during a regular dual-choice enrollment period that begins a minimum of 12 months after the disenrollment date.

E. RECOVERY OF EXCESS PAYMENTS

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

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

F. LIMIT ON ASSIGNABILITY OF BENEFITS

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

G. SEVERABILITY

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

H. SUBROGATION

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

- The third party or any liability or other insurance covering the third party

- The Participant's own uninsured motorist insurance coverage
- Under-insured motorist insurance coverage
- Any medical payments, no-fault or school insurance coverages which are paid or payable.

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

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

In the event the Participant can recover any amounts, for an Injury or Illness for which the insurer provides benefits, by initiating and processing a claim pursuant to a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the Participant shall either assert and process such claim and immediately turn over to the insurer the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the insurer in writing to prosecute such claim on behalf of the and in the name of the Participant, in which case the insurer shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a Participant fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the Participant's right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the Participant shall reimburse the insurer for all amounts theretofore or thereafter paid by the insurer which would have otherwise been recoverable under such acts and

the insurer shall not be required to provide any future benefits for which recovery could have been made under such acts but for the Participant's failure to meet the obligations of the subrogation provisions of this contract. The Participant shall advise the insurer immediately, in writing, if and when the Participant files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. PROOF OF CLAIM

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

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

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

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

J. GRIEVANCE PROCESS

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

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

the Health Plan and/or PBM. The Health Plan and/or PBM will advise You of Your right to appeal to the Department within 60 days of the date of the final grievance decision letter from the Health Plan and/or PBM.

You may also request an independent review per 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 or whether a treatment or service is Experimental. These appeals are reviewed only to determine whether the Health Plan breached its contract with the Group Insurance Board.

WHERE TO GET MORE INFORMATION

If you need additional information regarding:

Benefits	Contact the health plan or Pharmacy
Exclusions	Benefit Manager (PBM) directly.
Limitations	Addresses, web sites*, and telephone numbers
Participating Providers	are listed on the inside back cover of the <i>It's Your Choice: Decision Guide</i> .

- * When using health plan web sites for benefit and provider data, ensure that you are accessing State of Wisconsin program specific information. If you are not sure, call the plan.

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

Employee Trust Funds (ETF)
P. O. 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 must be submitted on approved ETF forms. Annuitants & Continuant should contact ETF.
- Additional information is available on ETF's web site at **etf.wi.gov**.
- Comments and suggestions regarding the It's Your Choice booklets should be directed to the Program Manager – Health Plans, Division of Insurance Services.

