Standard PPO Plan

Health Care Benefit Plan
Wisconsin Group Insurance Board

Department of Employee Trust Funds
P.O. Box 7931 • 801 W. Badger Rd., Madison, WI 53707-7931

WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

ET-2112 (REV 1/2013)

GENERAL INFORMATION ABOUT YOUR PLAN

The STANDARD Group Health Insurance Plan is available to State of Wisconsin EMPLOYEES, ANNUITANTS, and their eligible DEPENDENTS, regardless of residence. All medical expenses covered under your PLAN as described in this booklet are paid for by The State of Wisconsin. This Plan is administered by Wisconsin Physicians Service Insurance Corporation (WPS) under an agreement between The State of Wisconsin and WPS.

All SERVICES should be provided by a PREFERRED PROVIDER in order to result in the lowest out-of-pocket cost to you.

The PLAN reserves the right to modify the list of PREFERRED 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 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). A PARTICIPANT who is in her second or third trimester of pregnancy may continue to have access to her PREFERRED PROVIDER until the completion of post-partum care for herself and the infant.

This booklet is devoted to STANDARD PLAN BENEFITS and highlights the provisions of the Plan. Be sure to familiarize yourself with its contents, and keep it in a safe place where you can refer to it quickly when you need it.

Alternate HEALTH CARE PLANS are also available in specific limited geographical areas. Those plans are generally known as Health Maintenance Organizations (HMOs) and actually compete against the STANDARD PLAN in cost, service and BENEFIT level. Before making an enrollment decision, all PLANS operating in your locality should be investigated so the PLAN most appropriate to your needs is selected.

In the event of a conflict between the CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

There has been some confusion about preauthorization and pre-certification in the past. The following information is intended to help you understand the requirements.

Preauthorization – while you are not required to obtain preauthorization for any outpatient services, if you are concerned as to whether your service will be payable and at what cost, a preauthorization is recommended.

Pre-certification – to avoid a potential benefit reduction on inpatient services, you, a family member, or a provider must notify WPS about any emergency or non-emergency inpatient hospitalization to request pre-certification of services.

Estimation of Out-of-Pocket Expenses (WI ACT 146) – At the written request of our PARTICIPANTS, WPS will provide a good faith estimate of the reimbursement that the PLAN will expect to

pay and the PARTICIPANT'S responsibility (out-of-pocket costs) for a specified health care service that is being considered. Note: This process does not take the place of a preauthorization, prior approval or precertification.

Further information appears in this benefit booklet under the Preauthorization and WPS Medical Management Care Program sections.

Other information of which you must be aware is contained in two brochures titled "It's Your Choice". Those brochures compare BENEFITS of STANDARD, SMP and all available HMOs and covers the following:

- Cancellation
- Change in family status
- Claims
- Complaint process
- Conversion
- Continuation of coverage after loss of eligibility
- Coordination of benefits
- Coverages
- Dependents
- Discharge
- Effective date
- Eligibility
- Enrollment
- ID Cards
- Late enrollment
- Layoff
- Leave of absence
- Payroll deductions
- Pharmacy Benefit Manager
- Retirement
- State contribution toward premium
- Surviving spouse/dependent

If you have specific questions pertaining to coverage, please contact WPS at 1-800-634-6448. You can also visit us at the following locations:

WPS - Madison Office
1751 West Broadway
Madison, Wisconsin 53713

WPS - Appleton Office
1500 N. Casaloma Drive, Suite 202
Appleton, Wisconsin 54912

WPS - Eau Claire Office
2519 N. Hillcrest Parkway, Suite 200
Altoona, Wisconsin 54720

WPS - Milwaukee Office
111 W. Pleasant Street, Suite 110
Milwaukee, Wisconsin 53212

WPS - Wausau Office
1800 W. Bridge Street, Suite 200
Wausau, Wisconsin 54401

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DEFINITIONS

The following terms, when used and capitalized in this HEALTH BENEFIT PLAN or any supplements, endorsements or riders, are defined as follows:

ADVERSE DETERMINATION means a determination that involves all of the following:

1. WPS reviewed an admission to, or continued stay in, a health care facility, the availability of care, or other TREATMENT that is described as a covered service.

2. Based on the information provided, WPS determined that the TREATMENT does not meet WPS requirements for MEDICAL NECESSITY, appropriateness, health care setting, level of care or effectiveness;

3. As a result, WPS reduced, denied, or terminated BENEFITS for the TREATMENT.

ANNUITANT means any retired EMPLOYEE of the State of Wisconsin who: (1) is receiving an immediate annuity under the Wisconsin Retirement System; or (2) is an EMPLOYEE who retires after 20 years of creditable service; (3) is receiving a long-term disability benefit under Wis. Adm. Code § 50.40; or (4) is receiving a disability benefit under Wis. Stats. § 40.65.

BENEFITS mean payments for HOSPITAL SERVICES, PROFESSIONAL SERVICES and OTHER SERVICES under the HEALTH BENEFIT PLAN.

BIOLOGICALS means complex substances or products of organic or synthetic origin, other than food, depending for their action on the processes effecting immunity when used in immunization against or diagnosis and TREATMENT of disease or obtained or standardized by biological methods. Some examples are vaccines, serums, or antigens.

BOARD means the Group Insurance Board.

BONE MARROW TRANSPLANTATION means the mixing of blood and bone marrow from a PARTICIPANT or a compatible donor by means of multiple bone punctures performed under anesthesia and transplanted to the recipient.

CALENDAR YEAR means the period that starts with a PARTICIPANT'S initial EFFECTIVE DATE of coverage under this CONTRACT and ends on December 31 of such year. Each following CALENDAR YEAR shall start on January 1 of any year and end on December 31 of that year.

CERTIFIED NURSE MIDWIFE means a person who is a registered nurse and is certified to practice as a nurse midwife by the American College of Nurse Midwives and by either the State of Wisconsin or by the state in which he/she practices.

CHARGE means an amount for a HEALTH CARE SERVICE provided by a HEALTH CARE PROVIDER that is reasonable, as determined by WPS, when taking into consideration, among other factors determined by WPS: (a) amounts charged by HEALTH CARE PROVIDERS for similar HEALTH CARE SERVICES when provided in the same general area under similar or comparable circumstances; (b) WPS' methodology guidelines; (c) pricing guidelines of any third party responsible for pricing a claim; and (d) the negotiated rate determined by WPS in accordance with the applicable contract between WPS and a preferred provider. The term "area" means a county or other geographical area which WPS determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. In some cases the amount WPS determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the HEALTH CARE

SERVICE. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

Benefits for charges for covered bilateral and multiple surgical procedures and for a covered surgical procedure that requires a surgical assistant to be present are determined by WPS only as described in section “BENEFIT PROVISIONS”, subsection “PROFESSIONAL and OTHER SERVICES” paragraphs 1. b. c., d., and e.

In some cases WPS may determine that the HEALTH CARE PROVIDER or its agent didn’t use the appropriate billing code to identify the HEALTH CARE SERVICE provided to a PARTICIPANT. WPS reserves the right to recodify and assign a different billing code to any HEALTH CARE SERVICES that WPS determines was not billed using the appropriate billing code, for example unbundled codes and unlisted codes.

COCHLEAR IMPLANT means any implantable instrument or device that is designed to enhance hearing.

COINSURANCE means a portion of the CHARGE for BENEFITS for which the PARTICIPANT is responsible. COINSURANCE will not be reduced by refunds, rebates, or any other form of negotiated post-payment.

COMPLICATION OF PREGNANCY means a condition needing medical TREATMENT before or after termination of pregnancy. The health condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis; cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that can't be classified as a distinct COMPLICATION OF PREGNANCY but are connected with management of a difficult pregnancy. Also included are: terminated ectopic pregnancy, spontaneous termination that occurs during a pregnancy in which a viable birth is impossible, hyperemesis gravidarium, and preeclampsia.

CONFINEMENT means the period starting with a PARTICIPANT'S admission on an INPATIENT basis (more than 24 hours) to a GENERAL HOSPITAL, SPECIALTY HOSPITAL or a SKILLED NURSING FACILITY for TREATMENT of an ILLNESS or INJURY. CONFINEMENT ends with the PARTICIPANT'S discharge from the same HOSPITAL or other facility. If a PARTICIPANT is transferred to another HOSPITAL or other facility for continued TREATMENT of the same or related ILLNESS or INJURY, it’s still just one confinement.

CONGENITAL means a condition, which exists at birth.

CONTRACT means the Professional Services Administrative Services Only Contract between the BOARD and WPS and includes BENEFITS described in the HEALTH BENEFIT PLAN, which includes all attachments, supplements, endorsements or riders.

CONVENIENT CARE CLINIC: a medical clinic that is located in a retail store, supermarket or pharmacy providing covered health care services by nurse practitioners, physician assistants or physicians within the scope of their respective licenses. A CONVENIENT CARE CLINIC provides health care services to treat minor illnesses and injuries, and preventive services.

COPAYMENT: a specified dollar amount that the PARTICIPANT or family must pay each time those covered SERVICES are provided, subject to any maximums stated in the PLAN.

CUSTODIAL CARE means that type of care, which is designed essentially to assist a person to meet or maintain activities of daily living. It does not entail or require the continuing attention of trained medical personnel such as registered nurses and licensed practical nurses. CUSTODIAL CARE includes those HEALTH CARE SERVICES which constitute personal care such as help in walking and getting in and out of bed; assistance in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision of medication which usually can be self-administered. Care may also be custodial even though such care involves the use of technical medical skills. Notwithstanding the above, custodial care

is also provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a PHYSICIAN, 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. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE means a fixed dollar amount the PARTICIPANT must pay before the HEALTH BENEFIT PLAN will begin paying the CHARGES for BENEFITS.

DEPARTMENT means the Department of Employee Trust Funds.

DEPENDENT means, as provided herein, the SUBSCRIBER'S:

1. Spouse;

2. DOMESTIC PARTNER, if elected;

3. Child;

4. Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or covered DOMESTIC PARTNER prior to age 19;

5. Adopted child when placed in the custody of the parent as provided by Wis. Stats. § 632.896;

6. Stepchild;

7. Child of the DOMESTIC PARTNER covered under the PLAN;

8. Grandchild if the parent is a dependent child.

A grandchild ceases to be a DEPENDENT at the end of the month in which the dependent child (parent) turns age 18.

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 child cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, except that:

1. An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is dependent on the SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. WPS will monitor eligibility annually, notifying the DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. WPS, and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with WPS' determination.

2. After attaining age 26, as required by Wis. Stat. § 632.885, a DEPENDENT includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

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) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity or a court order is filed within 60 days of the birth.

A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes covered under the PLAN as an eligible EMPLOYEE.

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 DEPARTMENT, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in the CONTRACT.

DOMESTIC PARTNER means an individual that certifies in an affidavit along with his/her partner that they are in a domestic partnership as provided under Wis. Stats. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:

1. Each individual is at least 18 years old and otherwise competent to enter into a contract;

2. Neither individual is married to, or in a domestic partnership with, another individual;

3. The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law;

4. The two individuals consider themselves to be members of each other's IMMEDIATE FAMILY;

5. The two individuals agree to be responsible for each other's basic living expenses; and

6. The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

- **a.** Only one of the individuals has legal ownership of the residence;
- **b.** One or both of the individuals have one or more additional residences not shared with the other individual;
- **c.** One of the individuals leaves the common residence with the intent to return.

DURABLE MEDICAL EQUIPMENT means an item which can withstand repeated use and is, as determined by WPS:

1. Primarily used to serve a medical purpose with respect to an ILLNESS or INJURY;

2. Generally not useful to a person in the absence of an ILLNESS or INJURY;

3. Appropriate for use in the PARTICIPANT'S home; and

4. Prescribed by a PHYSICIAN.

All requirements of this definition must be satisfied before an item can be considered to be DURABLE MEDICAL EQUIPMENT.

EFFECTIVE DATE means the date, as certified by the DEPARTMENT and shown on the records of the PLAN in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

EMERGENCY MEDICAL CARE means HEALTH CARE SERVICES directly provided by a HEALTH CARE PROVIDER to treat a PARTICIPANT'S medical emergency. A medical emergency is 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:

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.

EMPLOYEE means an eligible EMPLOYEE of the State of Wisconsin as defined under Wis. Stats. § 40.02 (25), or an eligible EMPLOYEE as defined under Wis. Stats. § 40.02 (46) or 40.19 (4) (a), of an EMPLOYER as defined under Wis. Stats. § 40.02 (28), other than the State, which has acted under Wis. Stats. § 40.51 (7), to make health care coverage available to its EMPLOYEES.

EMPLOYER means the employing State agency or participating local government.

EXPEDITED GRIEVANCE means a grievance where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the PARTICIPANT or the ability of the PARTICIPANT to regain maximum function.

2. In the opinion of the PHYSICIAN with knowledge of the PARTICIPANT'S medical condition, the PARTICIPANT is subject to severe pain that cannot be adequately managed without the care of TREATMENT as an EXPEDITED GRIEVANCE.

3. A PHYSICIAN with knowledge of the PARTICIPANT'S medical condition determines that the GRIEVANCE shall be treated as an EXPEDITED GRIEVANCE.

EXPEDITED REVIEW means a situation where the standard EXTERNAL REVIEW process would jeopardize the PARTICIPANT'S life, health, or ability to regain maximum function.

EXPERIMENTAL/INVESTIGATIVE means, as determined by WPS' Corporate Medical Director, the use of any HEALTH CARE SERVICE for a PARTICIPANT'S ILLNESS or INJURY, that, at the time it is used, meets one or more of the following:

1. Requires approval that has not been granted by the appropriate federal or other governmental agency such as, but not limited to, the federal Food and Drug Administration (FDA); or

2. Isn't yet recognized as acceptable medical practice throughout the United States to treat that ILLNESS or INJURY.

3. Is the subject of either: (a) a written investigational or research protocol; or (b) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (c) an ongoing phase I, II or III clinical trial, except as required by law; or (d) an ongoing review by an Institutional Review Board (IRB); or

4. Doesn't have either: (a) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (b) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning such treatment,

service or supply and reflecting its recognition and reproducibility by non-affiliated sources we determine to be authoritative.

The criteria that WPS uses for determining whether a HEALTH CARE SERVICE is considered to be EXPERIMENTAL/INVESTIGATIVE and, therefore, not covered for a particular ILLNESS or INJURY include, but are not limited to:

1. Whether the HEALTH CARE SERVICE is commonly performed or used on a widespread geographic basis;

2. Whether the HEALTH CARE SERVICE is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States;

3. The failure rate and side effects of the HEALTH CARE SERVICE;

4. Whether other, more conventional methods of treating the ILLNESS OR INJURY have first been exhausted by the PARTICIPANT;

5. Whether the HEALTH CARE SERVICE is MEDICALLY NECESSARY;

6. Whether the HEALTH CARE SERVICE is recognized as not EXPERIMENTAL or INVESTIGATIVE by MEDICARE, Medicaid and other third party payers (including insurers and self-funded plans).

EXTERNAL REVIEW means a review of WPS' decision conducted by an INDEPENDENT REVIEW ORGANIZATION.

FAMILY COVERAGE means coverage applies to a SUBSCRIBER, his/her spouse or DOMESTIC PARTNER, and his/her eligible dependent children, provided the SUBSCRIBER properly enrolled for family coverage under the PLAN.

GENERAL HOSPITAL means an institution, which is licensed as a HOSPITAL which is accredited by the Joint Commission on Accreditation of Hospitals providing 24-hour continuous HEALTH CARE SERVICES to confined patients. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, TREATMENT and care of injured or sick persons. A professional staff of PHYSICIANS and surgeons must provide or supervise its HEALTH CARE SERVICES. It must provide general hospital and major surgical facilities and HEALTH CARE SERVICES. It can't be:

1. A convalescent or SKILLED NURSING FACILITY unit within or affiliated with the HOSPITAL;

2. A clinic;

3. A nursing, rest or convalescent home, or SKILLED NURSING FACILITY;

4. An institution operated mainly for care of the aged or for TREATMENT of mental disease, drug addiction or alcoholism; or

5. A sub-acute care center, health resort, spa or sanitarium.

GRAFTING means the implanting or transplanting of any tissue or organ.

GRIEVANCE means any dissatisfaction with the provision of WPS' HEALTH CARE SERVICES or claims practices that is expressed in writing to WPS by, or on behalf of, the PARTICIPANT.

GUIDELINES means guidelines for comprehensive major medical plans seeking Group Insurance Board approval to participate under the State of Wisconsin Group Health Benefit Program.

HEALTH BENEFIT PLAN/PLAN means the part of this CONTRACT that provides BENEFITS for HEALTH CARE SERVICES.

HEALTH CARE PROVIDER means any person, institution or other entity licensed by the state in which he/she is located to provide HEALTH CARE SERVICES covered by the PLAN to a PARTICIPANT within the lawful scope of his/her license.

HEALTH CARE SERVICES means TREATMENT, services, procedures, drugs or medicines, devices or supplies directly provided to a PARTICIPANT and covered under the PLAN, except to the extent that such TREATMENT, services, procedures, drugs or medicines, devices or supplies are limited or excluded under the PLAN.

HEARING AID means any externally wearable instrument or device designed for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except batteries and cords.

HOME CARE means HEALTH CARE SERVICES provided to a PARTICIPANT in his/her home under a written home care plan. The attending PHYSICIAN must set up the home care plan. Such plan must be approved in writing by that PHYSICIAN. He/she must review is at least every two months; but this can be less frequent if he/she decides longer intervals are enough and WPS agrees.

HOSPICE CARE means HEALTH CARE SERVICES provided to a terminally ill PARTICIPANT in order to ease pain and to make a PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided by or coordinated by a MEDICARE certified HOSPICE CARE facility under a HOSPICE CARE program.

HOSPITAL means a GENERAL HOSPITAL and a SPECIALTY HOSPITAL.

HOSPITAL SERVICES means ROOM ACCOMMODATIONS and all SERVICES, equipment, medications and supplies that are furnished, provided by and used in the HOSPITAL or SKILLED NURSING FACILITY to which the PARTICIPANT is admitted as a registered patient.

ILLNESS means a PHYSICAL ILLNESS, alcoholism, drug abuse or NERVOUS OR MENTAL DISORDER. All ILLNESS existing simultaneously are considered one ILLNESS. Successive periods of ILLNESS due to the same or related causes are considered one ILLNESS. An ILLNESS is deemed terminated:

1. In the case of a PARTICIPANT, upon the resumption of all duties of his/her occupation on a full time basis for at least 30 consecutive days.

2. In the case of a DEPENDENT, upon the resumption in full of normal activities for at least 30 consecutive days.

3. In any event, when, after a PARTICIPANT receives any medical or HOSPITAL TREATMENT or care (whether or not payable under this CONTRACT), a period of at least 30 consecutive days intervene before the PARTICIPANT again receives TREATMENT or care.

IMMEDIATE FAMILY means the PARTICIPANT'S spouse or DOMESTIC PARTNER, children, parents, grandparents, brothers and sisters and their own spouses or DOMESTIC PARTNERS.

IMPLANTATION means the insertion of an organ, tissue, prosthetic or other device in the body.

INCIDENTAL: associated SERVICES or items which are integral to the performance of another SERVICE or item, or which does not add significant time or effort to the other SERVICE or item.

INDEPENDENT REVIEW ORGANIZATION means an entity approved by the Office of the Commissioner of Insurance to review WPS' decisions.

INJURY means bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes. An accident caused by chewing resulting in damage to a PARTICIPANT'S teeth is not considered an INJURY.

INPATIENT means when a PARTICIPANT admitted as a bed patient to a health care facility.

LAYOFF means the same as "leave of absence" as defined under Wis. Stats. § 40.02 (40).

LICENSED SKILLED NURSING FACILITY means a skilled nursing facility licensed as a skilled nursing facility by the state in which it is located. The facility must be staffed, maintained and equipped to provide these skilled nursing services continuously: observation and assessment; care; restorative and activity programs. These must be under professional direction and medical supervision as needed.

MAINTENANCE CARE means ongoing care delivered after the acute phase of an illness 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 WPS after reviewing an individual's case history or TREATMENT plan submitted by a provider.

MATERNITY SERVICES means PROFESSIONAL SERVICES for pre- and post-natal care. This includes: laboratory procedures; delivery of the newborn; caesarean sections; and care for miscarriages.

MEDICALLY NECESSARY means a HEALTH CARE SERVICE directly provided to a PARTICIPANT 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 WPS:

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 HEALTH CARE SERVICE which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner and supported by information contained in a PARTICIPANT'S medical record or from other relevant sources.

The fact that a PHYSICIAN or OTHER HEALTH CARE PROVIDER has prescribed, ordered, or recommended or approved a HEALTH CARE SERVICE does not in itself make it MEDICALLY NECESSARY or otherwise eligible for payment.

MEDICAL SERVICES means PROFESSIONAL SERVICES recognized by doctors of medicine in the TREATMENT of ILLNESS or INJURY. Not included are: MATERNITY SERVICES; surgery; anesthesiology; pathology; and radiology.

MEDICAL SUPPLIES means items that are, as determined by WPS:

1. Primarily used to treat an ILLNESS or INJURY;

2. Generally not useful to a person in the absence of an ILLNESS or INJURY;

3. The most appropriate items which can safely be provided to a PARTICIPANT and accomplish the desired end result in the most economical manner; and

4. Prescribed by a PHYSICIAN. The item's primary function must not be for comfort or convenience.

MEDICARE means benefits available under Title XVIII of the Social Security Act of 1965, as amended.

MISCELLANEOUS HOSPITAL EXPENSE means the CHARGES for regular HOSPITAL expenses (but not room and board, nursing services, and ambulance services) covered under the PLAN for TREATMENT of an ILLNESS or INJURY requiring either inpatient hospitalization or outpatient HEALTH CARE SERVICES at a HOSPITAL. For outpatient HEALTH CARE SERVICES, this includes CHARGES for use of the HOSPITAL'S emergency room and for EMERGENCY MEDICAL CARE provided to a PARTICIPANT at the HOSPITAL. MISCELLANEOUS HOSPITAL EXPENSES include take-home drugs.

MORBID OBESITY/MORBIDLY OBESE means when a PARTICIPANT has a five year history of a Body Mass Index (BMI) greater than 35. Body Mass Index is defined as the PARTICIPANT'S weight in kilograms divided by the square of their height in meters. A PHYSICIAN must define MORBID OBESITY utilizing the method stated in this definition.

NERVOUS OR MENTAL DISORDER means any condition classified as a neurosis, psychoneurosis, psychopathy or psychosis.

NON-PREFERRED PROVIDER means a health care provider who has not entered into a written preferred provider agreement with the health care network selected by the SUBSCRIBER.

NURSE PRACTITIONER means an individual who is licensed as a registered nurse under Chapter 441, Wisconsin Statutes, as amended, or the laws and regulations of another state and who satisfies any of the following: (1) is certified as a primary care nurse practitioner or clinical nurse specialist by the American Nurses/ Association or by the National Board of Pediatric Nurse Practitioners and Associates; (2) holds and master's degree in nursing from an accredited school of nursing; (3) prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least four months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program; or (4) has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the deliver of primary care but that does not meet the requirements of (3) above, and has performed an expanded role in the deliver of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

ORAL SURGERY means an operative procedure to correct a problem in the oral cavity.

OTHER COVERAGE means any group or franchise contract, policy, plan or program of prepaid service care or insurance arranged through any employer, trustee, union or association including, but not limited to, disability, health and accident or sickness care coverage, or the medical payments provisions of an automobile insurance policy, any or all of which would provide BENEFITS for medical care of any nature either on a service or expense incurred basis if this CONTRACT was not in effect.

OTHER SERVICES means those SERVICES, if any, specified in this CONTRACT other than HOSPITAL SERVICES and PROFESSIONAL SERVICES.

OUT-OF-POCKET LIMIT means the total amount of DEDUCTIBLE and COINSURANCE that a PARTICIPANT must pay each CALENDAR YEAR.

OUTPATIENT means when a PARTICIPANT who is admitted as a non-bed patient to receive HOSPITAL services.

PARTICIPANT means the SUBSCRIBER or any of the SUBSCRIBER'S DEPENDENTS who have been specified by the DEPARTMENT to the PLAN for enrollment and are entitled to BENEFITS.

PHYSICAL ILLNESS means a disturbance in a function, structure or system of the human body which causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of the health state of the function, structure or system of the human body. PHYSICAL ILLNESS includes pregnancy and COMPLICATIONS OF PREGNANCY. PHYSICAL ILLNESS does not include alcoholism, drug abuse, or a NERVOUS OR MENTAL DISORDER.

PHYSICIAN means a person who received a degree in medicine from an accredited college or university and is a medical doctor or surgeon licensed by the state in which he/she is located and provides HEALTH CARE SERVICES while he/she is acting within the lawful scope of his/her license. A PHYSICIAN is limited to the following:

1. Doctor of Medicine (M.D.);

2. Doctor of Osteopathy (O.S.);

3. Doctor of Dental Surgery (D.D.S.);

4. Doctor of Dental Medicine (D.D.M.);

5. Doctor of Surgical Chiropody (D.S.C.);

6. Doctor of Podiatric Medicine (D.P.M.);

7. Doctor of Optometry (O.D.);

8. Doctor of Chiropractic (D. C.).

When required by law to cover the HEALTH CARE SERVICES of any other licensed medical professional under this CONTRACT, a PHYSICIAN also includes such other licensed medical professional who: (1) is licensed by the state in which he/she is located; (2) is acting within the lawful scope of his/her license; and (3) provides a HEALTH CARE SERVICE which WPS determines is a covered expense under the PLAN.

POSTOPERATIVE CARE means the medical observation and care of a PARTICIPANT necessary for recovery from a covered surgical procedure and received within 30 days following the date of surgery. Medical observation and care received by the PARTICIPANT after this 30-day period ends is not POSTOPERATIVE CARE.

PREFERRED HEALTH CARE PROVIDER means a HEALTH CARE PROVIDER, other than a PREFERRED PHYSICIAN or a PREFERRED HOSPITAL, who has entered into a written preferred provider agreement with the HEALTH CARE PROVIDER network shown on a PARTICIPANT'S PLAN Identification Card. The Preferred Provider Directory is available on the Internet at www.wpsic.com/state or by request from WPS. Please note that PREFERRED PROVIDERS may change periodically. While the on-line Preferred Provider Directory is updated frequently, the presence of a provider's name in the listing does not guarantee or mean that that specific provider participates in that network at the time that a PARTICIPANT receives any service from that provider. However, HEALTH CARE PROVIDERS who leave the network but appear in the Preferred Provider Directory remain available for the entire CALENDAR YEAR except in cases of normal attrition (that is death, retirement or relocation). The PARTICIPANT may be required to pay a larger portion of the cost of his/her covered HEALTH CARE SERVICE if he/she sees any HEALTH CARE PROVIDER who is not a PREFERRED PROVIDER.

PREFERRED HOSPITAL means a HOSPITAL who has entered into a written preferred provider agreement with the HEALTH CARE PROVIDER network shown on a PARTICIPANT'S PLAN Identification Card. The Preferred Provider Directory is available on the Internet at www.wpsic.com/state or by request from WPS. Please note that PREFERRED PROVIDERS may change periodically. While the on-line Preferred Provider Directory is updated frequently, the presence of a provider's name in the listing does

not guarantee or mean that that specific provider participates in that network at the time that a PARTICIPANT receives any service from that provider. However, HEALTH CARE PROVIDERS who leave the network but appear in the Preferred Provider Directory remain available for the entire CALENDAR YEAR except in cases of normal attrition (that is death, retirement or relocation). The PARTICIPANT may be required to pay a larger portion of the cost of his/her covered HEALTH CARE SERVICE if he/she sees any HEALTH CARE PROVIDER who is not a PREFERRED PROVIDER.

PREFERRED PHYSICIAN means a PHYSICIAN who has entered into a written preferred provider agreement with the HEALTH CARE PROVIDER network shown on a PARTICIPANT'S PLAN Identification Card. The Preferred Provider Directory is available on the Internet at www.wpsic.com/state or by request from WPS. Please note that PREFERRED PROVIDERS may change periodically. While the on-line Preferred Provider Directory is updated frequently, the presence of a provider's name in the listing does not guarantee or mean that that specific provider participates in that network at the time that a PARTICIPANT receives any service from that provider. However, HEALTH CARE PROVIDERS who leave the network but appear in the Preferred Provider Directory remain available for the entire CALENDAR YEAR except in cases of normal attrition (that is death, retirement or relocation). The PARTICIPANT may be required to pay a larger portion of the cost of his/her covered HEALTH CARE SERVICE if he/she sees any HEALTH CARE PROVIDER who is not a PREFERRED PROVIDER.

PREFERRED PROVIDER means a PREFERRED HOSPITAL, PREFERRED PHYSICIAN or PREFERRED HEALTH CARE PROVIDER.

PREMIUM means the rates as determined by the Group Insurance Board plus the administration fees required by the BOARD. These rates may be revised by the PLAN annually, effective on each succeeding January 1 following the EFFECTIVE DATE of this CONTRACT.

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 the assessment of laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.

PROFESSIONAL SERVICES means HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PHYSICIAN of the PARTICIPANT'S choice to treat his/her ILLNESS or INJURY. Such HEALTH CARE SERVICES include HEALTH CARE SERVICES provided by a certified registered nurse anesthetist, registered or licensed practical nurse, laboratory/x-ray technician and physician assistant provided: (a) such person is lawfully employed by the supervising PHYSICIAN or the facility where the HEALTH CARE SERVICE is provided; and (b) he/ she provides an integral part of the supervising PHYSICIAN'S PROFESSIONAL SERVICES while the PHYSICIAN is present in the facility where the HEALTH CARE SERVICE is provided. For HEALTH CARE SERVICES provided in a convenient care clinic, the requirement in (b) above does not apply. With respect to such HEALTH CARE SERVICES provided by a registered nurse or licensed practical nurse, laboratory/x-ray technician and physician assistant, such HEALTH CARE SERVICES must be billed by the supervising PHYSICIAN or the facility where the HEALTH CARE SERVICE is provided.

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 (intraarterial) injections or any drug administered through infusion.

SERVICES means HOSPITAL SERVICES, MATERNITY SERVICES, MEDICAL SERVICES, OTHER SERVICES, PROFESSIONAL SERVICES, SURGICAL SERVICES, or any other service directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER, as determined by WPS.

SINGLE COVERAGE means coverage applies only to a SUBSCRIBER. To be covered, an eligible EMPLOYEE must be properly enrolled and approved for coverage under the PLAN.

SKILLED NURSING CARE means HEALTH CARE SERVICES furnished on a PHYSICIAN'S orders which requires the skills of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the direct supervision of such professional personnel.

SKILLED NURSING FACILITY: An institution (or part of one) that: (a) is operated pursuant to law; (b) primarily engages in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; (c) provides continuous twenty-four (24) hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and (d) maintains a daily medical record of each patient. Except incidentally, it isn't a home or facility used primarily for rest, drug addicts, alcoholics, treatment of mental diseases or disorders, or custodial or educational care.

SMP means State Maintenance Plan.

SPECIALTY HOSPITAL means a short-term SPECIALTY HOSPITAL approved by WPS and the State, licensed and accepted by the appropriate State or regulatory agency to provide diagnostic SERVICES and TREATMENT for patients who have specified medical conditions. Such short-term SPECIALTY HOSPITALS include, for example, psychiatric, alcoholism and drug abuse, orthopedic and rehabilitative hospitals.

STANDARD PLAN means this CONTRACT excluding Wisconsin Public Employers and Medicare Plus coverage.

SUBSCRIBER means an EMPLOYEE, ANNUITANT, or his/her surviving DEPENDENTS who have been specified by the DEPARTMENT to the PLAN for enrollment and who is entitled to BENEFITS.

SUPPLIES mean medical supplies, durable medical equipment or other supplies directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER, as determined by WPS.

SUPPORTIVE CARE means HEALTH CARE SERVICES provided to a PARTICIPANT whose recovery has slowed or ceased entirely, and only minimal rehabilitative gains can be demonstrated with continuation of such HEALTH CARE SERVICES.

SURGICAL SERVICES means an operative procedure performed by a PHYSICIAN and that is recognized by WPS for TREATMENT of an ILLNESS or INJURY. Such services must improve or restore bodily function. Such services include sterilization procedures, PREOPERATIVE CARE and POSTOPERATIVE CARE, legal abortions. Such services do not include the reversal of a sterilization procedure, ORAL SURGERY SERVICES or MATERNITY SERVICES.

TRANSITIONAL TREATMENT ARRANGEMENTS means SERVICES more intensive than OUTPATIENT visits but less intensive than an overnight stay in the HOSPITAL. Most often, transitional care will be rendered in a day treatment program that provides successive hours of therapy. We cover transitional SERVICES in the following settings:

1. A certified Adult Mental Health Day Treatment Program as defined in HFS 61.75 Wis. Adm. Code.

2. A certified Child/Adolescent Mental Health Day Treatment Program as defined as HFS 40.04 Wis. Adm. Code.

3. A certified AODA Day Treatment Program as defined in HFS 75.12(1) and (2) Wis. Adm. Code.

4. A certified Community Support Program as defined in HFS 63.03 Wis. Adm. Code.

5. A certified Residential AODA Treatment Program as defined in HFS 75.14(1) an (2) Wis. Adm. Code.

6. Intensive outpatient programs for the TREATMENT of substance abuse disorders provided in accordance with the criteria established by the American Society of Addiction Medicine.

7. SERVICES provided by a program certified under HFS 34.03 and provided in accordance with subchapter III HFS34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other providers for stabilization.

8. Out of state SERVICES and programs that are substantially similar to (1), (2), (3), (4) and (5) if the provider is in compliance with similar requirements of the state in which the health care provider is located.

TRANSPLANTATION means GRAFTING of tissue or organ, including parts or substances from the same body or from another body.

TREATMENT means management and care directly provided to a PARTICIPANT by a PHYSICIAN or other HEALTH CARE PROVIDER for the diagnosis, remedy, therapy, combating, or the combination thereof, of an ILLNESS or INJURY, as determined by WPS.

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION/WPS means the entity acting as the health claims administrator under the terms of an Administrative Services Agreement with the Board.

ANNUAL DEDUCTIBLE AMOUNT AND COPAYMENTS

The DEDUCTIBLE applies to all BENEFITS, unless the CONTRACT states otherwise.

Annual Deductible Amount for HEALTH CARE SERVICES Provided by a PREFERRED PROVIDER

The annual DEDUCTIBLE amount is $200.00 per PARTICIPANT, not to exceed $400.00 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated below will NOT be used to satisfy this annual DEDUCTIBLE amount.

Annual DEDUCTIBLE Amount for HEALTH CARE SERVICES Provided by a NON-PREFERRED PROVIDER

The annual DEDUCTIBLE amount is $500.00 per PARTICIPANT, not to exceed $1,000.00 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a NON-PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated above will NOT be used to satisfy this annual DEDUCTIBLE amount.

Emergency Room COPAYMENT

The COPAYMENT amount for a PARTICIPANT'S use of a hospital emergency room is $75.00. The copayment amount applies to each PARTICIPANT for each visit to the hospital emergency room. For each PARTICIPANT, CHARGES for covered expenses must add up to the COPAYMENT amount before BENEFITS are payable for CHARGES for the emergency room fee billed by the HOSPITAL for use of the hospital emergency room (not including PHYSICIAN CHARGES or MISCELLANEOUS HOSPITAL EXPENSES). No BENEFITS are payable for the CHARGES used to satisfy a PARTICIPANT'S COPAYMENT. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate COPAYMENT. The hospital emergency room COPAYMENT will be waived for that visit if the PARTICIPANT is admitted as a resident patient to the HOSPITAL directly from the HOSPITAL emergency room or for observation for 24 hours or longer. This COPAYMENT is in addition to the annual DEDUCTIBLE amount stated above.

COINSURANCE

COINSURANCE for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER

After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER at 90%, unless specifically stated otherwise in the PLAN.

COINSURANCE for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a NON-PREFERREDPROVIDER

After the DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a NON-PREFERRED PROVIDER at 70%, unless specifically stated otherwise in the PLAN, up to the annual out-of-pocket limit stated below.

COINSURANCE for Independent Anesthesiologists

After the PREFERRED PROVIDER annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 90% of the CHARGES for HEALTH CARE SERVICES provided and billed by an independent anesthesiologist, unless specifically stated otherwise in the PLAN.

COINSURANCE for Radiology, Pathology and Laboratory Services

After the PREFERRED PROVIDER annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 90% of the CHARGES for radiology, pathology and laboratory services for TREATMENT of an ILLNESS or INJURY. This includes x-rays, laboratory services, allergy testing, MRI's, CT scans, pap smears and mammograms.

COINSURANCE for HOSPITAL Emergency Room Visits

After the emergency room COPAYMENT and PREFERRED PROVIDER annual DEDUCTIBLE amount stated above are satisfied, BENEFITS are payable at 90% of the CHARGES for the emergency room fee billed by the HOSPITAL for use of the HOSPITAL emergency room, PHYSICIAN'S PROFESSIONAL SERVICES and MISCELLANEOUS HOSPITAL EXPENSES for HEALTH CARE SERVICES provided during the visit to the HOSPITAL emergency room.

COINSURANCE for Routine Physical Examinations and Other Preventive SERVICES when Required by Federal Law and Directly Provided to a PARTICIPANT by a PREFERED PROVIDER.

For SERVICES required by federal law, BENEFITS are payable at 100% of charges for routine physical examinations and other preventive services when provided by a PREFERRED PROVIDER, without application of the DEDUCTIBLE amount.

ANNUAL OUT-OF-POCKET LIMIT

Annual Out-of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER

The annual out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER is $800.00 per PARTICIPANT, not to exceed $1,600.00 per family. This total is made up of the annual DEDUCTIBLE and COINSURANCE amounts for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a NON-PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated below will NOT be used to satisfy this annual out-of-pocket limit.

Annual Out-Of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a NON-PREFERRED PROVIDER

The annual out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a NON-PREFERRED PROVIDER is $2,000.00 per PARTICIPANT, not to exceed $4,000.00 per family. This total is made up of the annual DEDUCTIBLE and COINSURANCE amounts for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a NON-PREFERREDPROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated above will NOT be used to satisfy this annual out-of-pocket limit.

No BENEFITS are payable for CHARGES used to satisfy the annual out-of-pocket limit, including a participant's annual DEDUCTIBLE and COINSURANCE amounts. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE and COINSURANCE amounts.

After the applicable annual out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in the PLAN, incurred by the PARTICIPANT during the remainder of the CALENDAR YEAR, subject to all other terms, conditions and provisions of the PLAN.

BENEFIT PROVISIONS

Subject to the annual DEDUCTIBLE amounts stated in section "Annual DEDUCTIBLE Amount", BENEFITS are payable as stated in section "Coinsurance" and "Annual Out-of-Pocket Limit" for CHARGES for covered expenses a PARTICIPANT incurs in connection with a covered ILLNESS, INJURY or specific routine/preventive services, subject to all the provisions of the PLAN. Covered expenses must be incurred while the PARTICIPANT is covered under the PLAN. The DEDUCTIBLE must be satisfied for the CALENDAR YEAR in which the covered expenses are incurred before BENEFITS are payable, unless specifically stated otherwise in the PLAN.

BENEFITS are payable for CHARGES for covered expenses as described below. The PARTICIPANT is solely responsible to pay for all HEALTH CARE SERVICES not covered by the PLAN.

BENEFITS for CHARGES for covered CONFINEMENTS are subject to: (1) preadmission and continued stay certification requirements; and (2) the reductions in benefits shown in section "WPS Medical Management Program" for failure to comply with the certification requirements. Please see section "WPS Medical Management Program".

The following HEALTH CARE SERVICES are covered expenses. All HEALTH CARE SERVICES must be medically necessary and ordered by a physician because of an ILLNESS or INJURY, except for covered routine/preventive services. BENEFITS are not payable for MAINTENANCE CARE, CUSTODIAL CARE, SUPPORTIVE CARE, or any HEALTH CARE SERVICE to which an exclusion applies.

In 2011 for nervous or mental disorders and alcoholism and drug abuse treatment, annual day and dollar limit maximums are suspended, and services will be paid the same as any other illness pursuant to the Federal Mental Health Parity Act.

HOSPITAL SERVICES

Except as excluded in subsection "TRANSPLANTATIONS, IMPLANTATIONS and GRAFTING", and "COORDINATED HOME CARE, HOME CARE and HOSPICE CARE SERVICES" and section "Exclusions", BENEFITS are payable for CHARGES for the following HOSPITAL SERVICES for each PARTICIPANT admitted to a HOSPITAL or SKILLED NURSING FACILITY on or after his/her EFFECTIVE DATE, if those SERVICES are consistent with and MEDICALLY NECESSARY for the diagnosis and TREATMENT of the PARTICIPANT, as determined by WPS.

1. CONFINEMENT IN A HOSPITAL.

This applies to those PARTICPANTS admitted as INPATIENT in a HOSPITAL for TREATMENT of an ILLNESS or INJURY.

BENEFITS are payable for CHARGES as shown below.

a. CHARGES for room and board. Covered CHARGES shall include tube feedings in lieu of tray SERVICE when MEDICALLY NECESSARY, but not both;

b. CHARGES for nursing services;

c. CHARGES for MISCELLANEOUS HOSPITAL EXPENSES; and

d. CHARGES for intensive care unit room and board.

e. CHARGES for educational therapy that provides specialized instruction to a PARTICIPANT concerning their illness or injury prior to discharge.

With respect to CONFINEMENTS for pregnancy, the PLAN shall not limit the length of stay to less than: (a) 48 hours for a normal birth; and (b) 96 hours for cesarean delivery. However, a PARTICIPANT is free to leave the HOSPITAL earlier if the decision to shorten the stay is the mutual decision of the PHYSICIAN and mother.

2. CONFINEMENT in a SKILLED NURSING FACILITY.

BENEFITS are limited to a maximum of 120 days per calendar year, available only if PARTICIPANT is transferred from CONFINEMENT in a HOSPITAL to a SKILLED NURSING FACILITY.

3. BENEFIT Levels.

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. If the PARTICIPANT is transferred to another HOSPITAL or other facility for continued TREATMENT of the same or related ILLNESS or INJURY, it's still just one CONFINEMENT.

OUTPATIENT MISCELLANEOUS HOSPITAL EXPENSES

BENEFITS are payable for OUTPATIENT MISCELLANEOUS HOSPITAL EXPENSES. This includes use of operating, delivery, and TREATMENT rooms and equipment; dressings, supplies, casts and splints. Also included are:

1. First aid INJURY care. Includes subsequent care for the same INJURY or surgical care.

2. EMERGENCY MEDICAL CARE. The ILLNESS' final diagnosis or degree of severity must confirm that immediate medical care was required.

3. Chemotherapy, surgical procedures and HOSPITAL SERVICES in connection with medically recognized procedures performed as a substitute for surgery. Includes subsequent care for the same INJURY or surgical care.

4. Laboratory tests and X-ray examinations, including high-tech radiology tests (MRI, MRA, CT or CTA scan, PET scans and nuclear stress tests). WPS' prior authorization is required for high-tech radiology tests, including related SERVICES, except those provided as EMERGENCY MEDICAL CARE. If a PARTICIPANT does not receive WPS' preauthorization, benefits are not payable under the PLAN. However, if a claim is denied solely because the PARTICIPANT did not receive WPS' prior approval, WPS may review the SERVICES for payment under the PLAN based on medical necessity provided the PARTICIPANT requests WPS to review the claim and provides additional documentation from his/her PHYSICIAN as to the medical necessity of the high-tech radiology test.

5. Radiation therapy.

PROFESSIONAL AND OTHER SERVICES

Except as excluded in subsection "TRANSPLANTATIONS, IMPLANTATIONS and GRAFTING", and "COORDINATED HOME CARE, HOME CARE and HOSPICE CARE SERVICES" and section "Exclusions",

BENEFITS are payable for CHARGES for the following PROFESSIONAL SERVICES and OTHER SERVICES for each PARTICIPANT on or after his/her EFFECTIVE DATE, if those SERVICES are consistent with and MEDICALLY NECESSARY for the diagnosis and TREATMENT of the PARTICIPANT, as determined by WPS.

1. SURGICAL SERVICES.

SURGICAL SERVICES, other than ORAL SURGERY SERVICES, wherever performed. BENEFITS for ORAL SURGERY SERVICES are shown in paragraph 7. below.

a. BENEFITS are payable for SURGICAL SERVICES for MORBID OBESITY, including gastroplasty and gastric bypass surgery.

In order for benefits to be payable at the PREFERRED PROVIDER level of benefits, such SURGICAL SERVICES must be provided by a preferred provider who has met CMS' minimum facility standards for Centers of Excellence for bariatric surgery and has been certified by the American College of Surgeons or the American Society of Bariatric Surgeons. All other health care providers shall be payable at the non-preferred level of benefits.

BENEFITS are payable only for PARTICIPANTS with a five year history of BMI greater than 40 when all of the following criteria are met:

(1) Within the past twelve months, there must be appropriate documentation of at least six consecutive months of compliance with a professionally supervised weight loss program. In cases where the PARTICIPANT is not compliant, this criterion for approval will be considered unmet). Documentation must consist of actual progress notes for the dates of participation in the program. Participation which is summarized in the form of a letter is not acceptable. Appropriate documentation is as follows:

(a) The supervising physician's office notes demonstrate a reasonable frequency of office visits (at least once every four to six weeks) with clear evidence that weight reduction management was the primary service provided to the patient on that date; **OR**

(b) Dated progress notes from a registered dietician involved in the patient's program with a reasonable frequency of follow-up visits: **OR**

(c) Dated progress notes (generally weekly) from the weight loss program in which the patient is enrolled, such as Weight Watchers, Jenny Craig, etc; **OR**

(d) If, on the date of the initial evaluation of the patient at the bariatric surgery program, there is no documentation of (a), or (b) or (c) above, then there must be documentation in the bariatric surgery notes that the patient has been prospectively referred to a professionally supervised weight loss program for a minimum of six consecutive months.

(2) Post bariatric surgery diet: Patient/program must meet one of the following:

(a) With the support from a dietician, the patient has successfully completed a two week trial of the post-operative bariatric diet (consistent with the type of surgery that will be performed); **OR**

(b) The surgeon's pre-operative protocol requires the successful two week trial of the post-operative bariatric diet.

(3) A psychological evaluation that addresses and provides the necessary treatment for addiction and compliance concerns has been completed.

(4) Prior authorization is received from WPS.

(5) There has been no previous bariatric surgery performed;

(6) In addition to the criteria above, PARTICIPANTS with a five year history of BMI greater than 35, one of the following comorbid conditions must be documented:

(a) Coronary artery disease or obesity-related cardiomyopathy requiring medical management;

(b) Type 2 diabetes without adequate control despite the use of appropriate medications;

(c) Degenerative joint disease (including radiographic documentation) that requires medical management;

(d) Hyperlipidemia (total cholesterol greater than 300 that during the past six months has not been significantly reduced despite increased dosages of lipid-lowering agents or a three month trial of at least two different lipid-lowering agents);

(e) Dyslipidemia (LDL cholesterol greater than 130 for non-diabetic patients or greater than 100 in diabetic patients that during the past six months has not been significantly reduced despite increased dosages of lipid-lowering agents or a three month trial of at least two different lipid-lowering agents);

(f) Hypertension (systolic greater than 140 mmHg or a diastolic greater than 90 mmHg that has not been significantly reduced despite a minimum of six months of medical management);

(g) Severe sleep apnea (AHI greater than 40) not responsive to a three-month trial of CPAP therapy.

BENEFITS are not payable for the following surgeries: (a) biliopancreatic bypass without duodenal switch; (b) jejunoileal bypass; (c) long limb (greater than 150 cm) gastric bypass; (d) mini gastric bypass (Billroth procedure); (e) Fobi pouch; (f) bariatric surgery for the management and treatment of GERD and cholecystitis; (g) gastric balloon; and (h) endoscopic pleating/reduction (for example, Stomaphy X).

BENEFITS are not payable if any of the following conditions are documented: (1) current drug abuse; (2) active suicidal ideation; (3) personality disorder; (4) uncontrolled schizophrenia; (5) terminal disease; (6) uncontrolled depression; (7) significant chronic obstructive pulmonary disease; (8) an eating disorder that would prevent successful long-term weight loss after bariatric surgery (for example, anorexia or bulimia); (9) severe hiatal hernia; and (10) the PARTICIPANT is less than 18 years of age.

b. BENEFITS are payable for a covered surgical procedure that requires a surgical assistant to be present, as determined by WPS, only as follows. If WPS determines BENEFITS are payable for the SERVICES directly provided to a PARTICIPANT by a surgical assistant: (1) BENEFITS for the covered services of a PHYSICIAN surgical assistant will be paid up to a maximum of 15% of the charge WPS determines for that surgical procedure

performed by the PHYSICIAN; and (2) BENEFITS for the covered services of a surgical assistant who is not a PHYSICIAN will be paid up to a maximum of 10% of the CHARGE WPS determines for that surgical procedure performed by the PHYSICIAN.

c. BENEFITS payable for covered bilateral surgical procedures done at the same setting are limited to a maximum of one and one-half times the CHARGE WPS determines for the single surgical procedure. No additional BENEFITS are payable for those procedures. A bilateral surgical procedure is the same surgical or invasive medical procedure performed on similar anatomical parts which are on opposite sides of a body which are usually identified as either right or left (e.g. eyes, ears, arms, legs, hands, feet, breasts, lungs or kidneys).

d. BENEFITS payable for covered multiple surgical procedures, other than bilateral surgical procedures, are limited to a maximum of 100% of the CHARGE WPS determines for the primary surgical procedure and 50% of the CHARGE WPS determines for each additional procedure, other than procedures determined to be incidental or inclusive. A primary surgical procedure is the surgical procedure with the highest charge as determined by WPS. Multiple surgical procedures are more than one surgical or invasive medical procedure performed at the same setting, usually within the same related anatomical region, or same incision area.

e. BENEFITS are not payable for incidental surgical procedures which are performed at the same setting as a major covered surgical procedure, which is the primary procedure. Incidental surgical procedures are one or more surgical procedures performed through the same incision or operative approach as the primary surgical procedure with the highest CHARGE as determined by WPS and which, in WPS' opinion, are not clearly identified and/or do not add significant time or complexity to the surgical session. BENEFITS payable for incidental surgical procedures are limited to the CHARGE for the primary surgical procedure with the highest CHARGE, as determined by WPS. No additional BENEFITS are payable for those incidental surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an incidental surgical procedure (i.e., BENEFITS are payable for the hysterectomy, but not for the removal of the appendix).

2. MATERNITY SERVICES.

MATERNITY SERVICES, including: (a) prenatal and postnatal care; (b) laboratory procedures; (c) delivery of the natural newborn child; (d) cesarean sections; and (e) HEALTH CARE SERVICES for miscarriages.

3. MEDICAL SERVICES.

MEDICAL SERVICES for a PHYSICAL ILLNESS or INJURY, including second opinions. SERVICES must be provided: (a) in a HOSPITAL; (b) in a PHYSICIAN'S office; (c) in an urgent care center; (d) in a surgical care center; (e) in a convenient care clinic; or (f) in a PARTICIPANT'S home. These SERVICES do not include HOME CARE SERVICES covered elsewhere in this CONTRACT.

4. Anesthesia SERVICES.

Anesthesia SERVICES in connection with SERVICES that are a BENEFIT under this CONTRACT.

5. Radiation Therapy and Chemotherapy SERVICES.

Radiation therapy and chemotherapy SERVICES for therapeutic TREATMENT of covered benign or malignant conditions including CHARGES for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in TREATMENT.

6. Diagnostic SERVICES.

Diagnostic radiology and laboratory SERVICES directly provided to a PARTICIPANT for radiology and lab tests related to a covered PHYSICAL ILLNESS or INJURY. WPS' prior approval is required for outpatient high-tech radiology tests (MRI, MRA, CT or CTA Scan, PET scans and nuclear stress tests), including related SERVICES, except those provided as EMERGENCY MEDICAL CARE. If a PARTICIPANT does not receive WPS' prior approval, benefits are not payable under the PLAN. However, if a claim is denied solely because the PARTICIPANT did not receive WPS' prior approval, WPS may review the SERVICES for payment under the PLAN based on medical necessity provided the PARTICIPANT requests WPS to review the claim and provides additional documentation from his/her PHYSICIAN as to the medical necessity of the high-tech radiology test.

7. ORAL SURGERY SERVICES.

ORAL SURGERY SERVICES, including related consultation, x-rays and anesthesia, limited to the following procedures:

(a) surgical exposure or removal of impacted teeth;

(b) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(c) surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(d) apicoectomy (excision of the apex of the tooth root);

(e) excision of exostosis (bony outgrowth) of the jaws and hard palate;

(f) frenectomy;

(g) incision and drainage of cellulitis (tissue inflammation) of the mouth;

(h) incision of accessory sinuses, salivary glands or ducts;

(i) gingivectomy (excision of gum tissue to eliminate infection), includes osseous surgery, tissue and bone grafts;

(j) alveolectomy/alveoplasty;

(k) orthognathic surgery and osteotomies;

(l) apical curettage;

(m) gingival curettage under general anesthesia;

(n) removal of residual (retained) root;

(o) TREATMENT of fractured facial bones;

(p) vestibuloplasty;

(q) osteoplasty;

(r) transeptal fiberotomy;

(s) retrograde filling;

(t) hemisection;

(u) coronidectomy; and

(v) surgical removal of erupted teeth.

The extraction of teeth other than by surgery, dental implants, root canal procedures, filling, capping, recapping or other routine repair or maintenance of teeth, alveoplasty with extraction (D7310), and reconstruction of mandible coded 21244, 21245, 21248 and 21249 are excluded.

8. EMERGENCY MEDICAL CARE.

EMERGENCY MEDICAL CARE. Examples of conditions which could constitute EMERGENCY MEDICAL CARE:

(1) Acute allergic reactions;

(2) Acute asthmatic attacks;

(3) Convulsions;

(4) Epileptic seizures;

(5) Acute Hemorrhage;

(6) Acute appendicitis;

(7) Acute or suspected poisoning;

(8) Coma;

(9) Heart attack;

(10) Attempted suicide;

(11) Suffocation;

(12) Stroke;

(13) Drug overdoses;

(14) Loss of consciousness;

(15) Any condition for which the patient is admitted to the HOSPITAL as an INPATIENT.

9. Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDER TREATMENT.

a. OUTPATIENT TREATMENT of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS. BENEFITS are payable for CHARGES for TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS for a PARTICIPANT other than as an INPATIENT.

Such TREATMENT must be provided by:

(1) a program in an outpatient treatment facility, if both the program and facility are approved by the Department and established and maintained according to rules promulgated under Section 51.42 (7)(b), Wisconsin Statutes, as amended;

(2) a licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office;

(c) a psychologist licensed or certified by the state in which he/she is located; or

(4) a clinical social worker, marriage and family therapist or professional counselor licensed or certified by the state in which he/she is located to provide nonresidential services or the TREATMENT of NERVOUS OR MENTAL DISORDERS, alcoholism or drug abuse.

b. **TRANSITIONAL TREATMENT ARRANGEMENTS.** BENEFITS are payable for CHARGES for covered expenses incurred by a PARTICIPANT for TRANSITIONAL TREATMENT ARRANGEMENTS provided to that PARTICIPANT each CALENDAR YEAR.

The criteria that WPS uses to evaluate a transitional TREATMENT program or SERVICE to determine whether it is covered under the CONTRACT include, but are not limited to:

(1) the program is certified by the Department of Health and Family Services;

(2) the program meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;

(3) the specific diagnosis is consistent with the symptoms;

(4) the TREATMENT is standard medical practice and appropriate for the specific diagnosis;

(5) the multi-disciplinary team running the program is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider's program is located or the SERVICE is provided;

(6) see the definition of "MEDICALLY NECESSARY" in the definitions.

WPS will need the following information from the HEALTH CARE PROVIDER to help determine the MEDICAL NECESSITY of such program or SERVICE:

(1) a summary of the development of the PARTICIPANT'S ILLNESS and previous TREATMENT;

(2) a well defined TREATMENT plan listing TREATMENT objectives, goals and duration of the care provided under the TRANSITIONAL TREATMENT ARRANGEMENT program;

(3) a list of credentials for the staff who participated in the TRANSITIONAL TREATMENT ARRANGEMENT program or SERVICE, unless the program or SERVICE is certified by the Department of Health and Family Services.

c. Psychiatric therapy SERVICES provided to INPATIENTS for TREATMENT of NERVOUS OR MENTAL DISORDERS, alcoholism and drug abuse.

10. Ambulance SERVICE.

BENEFITS are payable for CHARGES for professional licensed ambulance SERVICE when necessary to transport a PARTICIPANT to or from a HOSPITAL subject to the PREFERRED PROVIDER DEDUCTIBLE and COINSURANCE. SERVICES include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance SERVICE is unavailable and such transportation is substantiated by a PHYSICIAN as being MEDICALLY NECESSARY.

11. TREATMENT of Temporomandibular Disorders.

BENEFITS are payable for diagnostic procedures and 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, including intraoral splint therapy, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Benefits for diagnostic procedures and non-surgical TREATMENT will be payable up to $1,250.00 per CALENDAR YEAR.

12. Routine Physical Examinations and Other Preventive Services.

BENEFITS are payable for: (a) routine physical examinations and related diagnostic services performed and billed by a PHYSICIAN; and (b) other preventive SERVICES when required by Federal Law, including women's preventive health services. Physical examinations requested by a third party are not covered under this CONTRACT.

13. Physical, Speech, Occupational, Respiratory and Aquatic Therapy.

Physical, speech, occupational, respiratory and aquatic therapy limited to a combined maximum of 50 visits per calendar year. An additional 50 visits may be available if additional visits are medically necessary and approved by WPS. Such therapy must be prescribed by a PHYSICIAN when necessitated by an ILLNESS or INJURY and provided by a PHYSICIAN, licensed physical, speech, occupational or respiratory therapist or any other HEALTH CARE PROVIDER approved by WPS other than one whom ordinarily resides in the PARTICIPANT'S home or who is a member of the PARTICIPANT'S IMMEDIATE FAMILY.

14. Dental SERVICES.

BENEFITS are payable for total extraction or total replacement of natural teeth by a PHYSICIAN when necessitated by an INJURY. The INJURY and TREATMENT must occur while the PARTICIPANT is continuously covered under this CONTRACT or a preceding CONTRACT provided through the BOARD. A dental repair method, other than extraction and replacement, may be considered if approved by WPS before the SERVICE is performed. This includes dentures but does not include dental implants.

BENEFITS are also payable for:

a. HOSPITAL or ambulatory surgery center CHARGES incurred, and anesthetics provided, in conjunction with dental care that is provided to a PARTICIPANT in a HOSPITAL or ambulatory surgery center provided: (1) the PARTICIPANT is a child under the age of five; (2) the PARTICIPANT has a chronic disability that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or (d) the PARTICIPANT has a medical condition that requires hospitalization or general anesthesia for dental care.

b. extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and

c. sealants on existing teeth to prepare the jaw for chemotherapy treatment of neoplastic disease.

15. MEDICAL SUPPLIES.

MEDICAL SUPPLIES prescribed by a PHYSICIAN. Such MEDICAL SUPPLIES include, but are not limited to:

a. Blood or blood plasma;

b. Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible;

c. Casts, splints, trusses, crutches, orthopedic braces and appliances, custom made orthotics, therapeutic contact lenses and cataract lenses following cataract surgery;

d. oxygen; and

e. rental of radium and radioactive isotopes.

16. DURABLE MEDICAL EQUIPMENT.

Rental of or, at the option of WPS, purchase of DURABLE MEDICAL EQUIPMENT such as, but not limited to: wheelchairs, hospital-type beds; and artificial respiration equipment. When the equipment is purchased, BENEFITS are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. If the DURABLE MEDICAL EQUIPMENT is purchased, BENEFITS are payable for CHARGES up to the purchase price of that DURABLE MEDICAL EQUIPMENT. Rental fees exceeding the purchase price, routine periodic maintenance and replacement of batteries are not covered.

17. OUTPATIENT Cardiac Rehabilitation SERVICES.

BENEFITS are payable for OUTPATIENT cardiac rehabilitation SERVICES. SERVICES must be approved by WPS and provided in an OUTPATIENT department of a HOSPITAL, in a medical center or clinic program. This BENEFIT applies only to 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. any other condition for which WPS determines cardiac rehabilitation as being appropriate for treating a PARTICIPANT'S medical condition.

BENEFITS are payable only for eligible PARTICIPANTS who begin an exercise program immediately following their discharge from a HOSPITAL for one of the conditions shown above. BENEFITS are limited to CHARGES for up to a maximum of 78 sessions per ILLNESS beginning with the first session in the supervised and monitored OUTPATIENT exercise program. Immediately is herein defined as commencing within three months following the date of SERVICE of the procedure. This time frame may be extended if individual circumstances warrant and are documented as MEDICALLY NECESSARY

BENEFITS are not payable for behavioral or vocational counseling. The BENEFIT limit stated above is available following a subsequent period of hospitalization for any of the conditions listed in this paragraph. No other BENEFITS for OUTPATIENT cardiac rehabilitation SERVICES are available under this CONTRACT.

18. BIOLOGICALS.

BENEFITS are payable for CHARGES for BIOLOGICALS, and prescription drugs prescribed by a PHYSICIAN and required to be administered by a professional provider during an office visit with a PHYSICIAN for TREATMENT of an ILLNESS or INJURY.

19. Licensed Free-Standing Surgical Center.

BENEFITS are payable for CHARGES for facility fees for HEALTH CARE SERVICES provided in a licensed free-standing surgical center.

20. Mammograms and Pap Smears.

Mammograms and pap smears must be performed by or under the direction of a PHYSICIAN or LICENSED NURSE PRACTITIONER. BENEFITS are payable for CHARGES for the following:

a. one routine examination by low-dose mammography of a female PARTICIPANT per CALENDAR YEAR;

b. routine taking and reading of pap smear or routine papanicolaou smear;

c. mammograms, pap smears and PSA tests provided in connection with an ILLNESS.

21. Equipment and Supplies for TREATMENT of Diabetes.

BENEFITS are payable for CHARGES incurred for the installation and use of an insulin infusion pump, and all other equipment and supplies, excluding insulin, used in the TREATMENT of diabetes.

Benefits for insulin syringes and needles, lancets, diabetic test strips, alcohol pads, dextrose (tablets and gel), auto injector, auto blood sampler, and glucose control solution are payable as stated below:

a. charges for the disposable supplies listed above when dispensed by a pharmacy are payable under the prescription drug benefits administered by the Pharmacy Benefits Manager;

b. charges for the disposable supplies listed above when dispensed by a health care provider other than a pharmacy are payable as stated in this paragraph 21.

This benefit is limited to the purchase of one pump per PARTICIPANT per CALENDAR YEAR. The PARTICIPANT must use the pump for at least 30 days before the pump is purchased. BENEFITS are also payable for CHARGES for diabetic self-management education programs.

22. Immunizations.

BENEFITS are payable CHARGES for immunizations including, but not limited to, the following: dipitheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; prevnar, and varicella. Immunizations for travel purposes are not covered. The annual DEDUCTIBLE and COINSURANCE amounts do not apply to immunizations provided to PARTICIPANTS to age six and for those immunizations required by Federal law.

23. Blood Lead Tests.

BENEFITS are payable for CHARGES for blood lead tests for PARTICIPANTS age five and under.

24. Breast Reconstruction Following Mastectomy.

BENEFITS are payable for CHARGES for breast reconstruction of the affected tissue following a mastectomy. Benefits are also payable for CHARGES for: surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prostheses; and physical complications for all stages of mastectomy, including lymphedemas.

25. Certified Nurse Midwife Services.

BENEFITS are payable for services provided by a nurse midwife when the services are performed in a clinic or hospital setting.

26. Contraceptives for Birth Control.

As required by Wis. Stat. §632.895 (17), BENEFITS are payable for charges for devices or medications used as contraceptives which require a prescription orand intervention by a physician or other licensed health care provider, including related health care services. Examples include:

a. Intrauterine devices (IUD);

b. Subdermal contraceptive implants;

c. Diaphragms;

d. Injections of medication for birth control.

Note: Benefits for prescription legend drugs purchased at a pharmacy purchased at a pharmacy are covered under the prescription legend drug benefits of the Pharmacy Benefit Manager.

Benefits are not payable for contraceptive devices or supplies which can be obtained without intervention by a physician or other licensed health care provider including, but not limited to, condoms and contraceptive foam or gel.

27. Self Administered Injectable Medications and Prescription Drugs Provided in a Physician's Office, Hospital or by a Home Health Agency.

BENEFITS are payable for CHARGES for self administered injectable medication, injectable and infusible medication, and prescription drugs when required to be used in a physician's office, a hospital, or by a home health agency during home care.

28. Hearing Aids and Cochlear Implants.

As required by Wis. Stat. §632.895 (16), BENEFITS are payable for charges for: (a) the cost of one hearing aid, per ear, per child every three years; (b) cochlear implants; and (c) treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear implants. This paragraph applies only to children under the age of 18 who are covered under the PLAN. Such hearing aids and cochlear implants must be prescribed by a physician or an audiologist in accordance with accepted professional medical or audiological standards. The child must be certified as deaf or hearing impaired by a physician or audiologist.

29. 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 payable up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services are not subject to contract exclusions and limitations that apply to any other illness.

30. Genetic Services.

BENEFITS are payable for charges for the following genetic services:

a. Genetic counseling provided to a PARTICIPANT by a PHYSICIAN, licensed or Master's trained genetic counselor or medical geneticist;

b. amniocentesis during pregnancy;

c. chorionic villus sampling for genetic and non-genetic testing during pregnancy;

d. identification of infectious agents such as the influenza virus;

e. compatibility testing for a PARTICIPANT who has been approved by WPS for a covered transplant;

f. prenatal cystic fibrosis testing when ordered by an obstetrician in accordance with recommendations from the American College of Medical Genetics (ACMG) and American Congress of Obstetricians and Gynecologists (ACOG);

g. molecular testing of pathological specimens. Such testing does not include testing of blood, except for (1) testing for the diagnosis of leukemia, lymphoma, or platelet abnormalities and (2) testing of the KRAS genetic variation for drug susceptibility; and

h. for the diagnosis or treatment of one of the illnesses listed below. WPS' prior approval is recommended for such genetic tests. If a PARTICIPANT does not receive WPS' prior approval, BENEFITS for such services may not be payable under the CONTRACT.

BENEFITS are payable if the disease being tested for is one of the following:

(1) Canavan Disease;

(2) Congenital Profound Deafness;

(3) Cystic Fibrosis for members who are not pregnant;

(4) Factor V Leiden Thrombophilia;

(5) Familial Adenomatous Polyposis Coli;

(6) Gaucher Disease;

(7) Hemoglobinopathies;

(8) Hereditary Hemochromatosis;

(9) Hereditary Non-Polyposis Colorectal Cancer;

(10) Long QT Syndrome;

(11) Mitochondrial Disorders;

(12) Myotonic Dystrophy;

(13) Niemann-Pick Disease;

(14) Retinoblastoma;

(15) Medullary Thyroid Cancer and Multiple Endocrine Neoplasia Type 2 RET testing;

(16) Breast and Ovarian Cancer Susceptibility. If approved by WPS, such tests provided by a PREFERRED PROVIDER will be payable at 100% of the CHARGES without application of the annual DEDUCTIBLE amounts;

(17) Tay-Sachs Disease; or

(18) Von Hippel-Lindau Disease.

Since this list may change from time to time, the PARTICIPANT should contact WPS by calling the Customer Service telephone number shown on your Identification Card, or log on to WPS' internet website at www.wpsic.com, for the most current list of covered diagnoses for genetic testing.

Genetic testing for the following will not be covered: (1) testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone; (2) testing for conditions which can not be altered by treatment or prevented by specific interventions; (3) testing solely for the purpose of informing the care or management of a participant's family members; (4) testing for drug therapy, i.e. pharmacogenetics; and (5) genetic testing for any condition that does not appear on the above list or as updated on the WPS Internet website.

All other genetic services require WPS' prior approval. If a PARTICIPANT does not receive WPS' approval prior to receiving genetic services, other than as stated above, BENEFITS may not be payable under the CONTRACT.

Genetic testing for the following will not be covered: (a) testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone; (b) testing for conditions which can not be altered by treatment or prevented by specific interventions; (c) testing solely for the purpose of informing the care or management of a participant's family members; and (d) testing for drug therapy, i.e. pharmacogeneticsted on the WPS Internet website.

31. Health and Behavior Assessments and Neuropsychological Testing.

BENEFITS are payable for health and behavior assessments and reassessments, diagnostic interviews and neuropsychological testing provided by a psychologist to treat a physical illness or injury.

32. Infertility Services.

BENEFITS are payable for Infertility diagnostic services directly provided to a PARTICIPANT. Once there has been a diagnosis of infertility, there are no further BENEFITS payable under the CONTRACT. Benefits are not payable for any laparoscopic procedure during which an ovum is manipulated for the purpose of fertility treatment even if the laparoscopic procedure includes other purposes.

33. Pain Management Treatment.

BENEFITS are payable for pain management treatment including injections and other procedures to manage a PARTICIPANT'S pain related to an illness or injury.

WPS' prior approval is recommended for the following pain management injections or procedures:

a. percutaneous intervertebral disc procedures (intradiscal electrothermal therapy (IDET), intradiscal electrothermal annuloplasty (IDEA), percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), nucleoplasty, laser assisted disc decompression (LADD), percutaneous disc decompression, chemonucleolysis ;

b. ablation (denervation) of the facet joint nerves;

c. facet joint injections and medical branch nerve blocks;

d. trigger point injections;

e. selective nerve root blocks and epidural injections, other than epidural injections provided to the pregnant member in connection with labor or delivery of a newborn child or due to surgery; and

f. sacroiliac joint injections;

g. artificial intervertebral disc replacement (lumbar artificial disc replacement (LADR) and intervertebral disc prosthesis.

If a PARTICIPANT does not receive WPS' prior approval, benefits for such pain management injections and procedures may not be covered under the CONTRACT.

TRANSPLANTATIONS, IMPLANTATIONS AND GRAFTING

Except as otherwise specifically excluded in this CONTRACT, according to BENEFITS available under this subsection, BENEFITS for CHARGES are payable for each PARTICIPANT receiving such SERVICES in connection with the BENEFITS described in this section on or after his/her EFFECTIVE DATE, if those SERVICES are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and TREATMENT of the PARTICIPANT, as determined by WPS, subject to all terms, conditions and provisions of this CONTRACT.

1. BENEFITS.

a. TRANSPLANTATIONS. The following TRANSPLANTATIONS are covered by this CONTRACT. Donor expenses are covered when included as part of the PARTICPANT'S (as the transplant recipient) bill. Separately billed donor-related services are not covered under this CONTRACT:

(1) Autologous (self to self) and allogenic (donor to self) BONE MARROW TRANSPLANTATIONS and peripheral blood stem cell rescue and/or TRANSPLANTATIONS used only in the TREATMENT of:

(a) Mydlodysplastic syndrome;

(b) Homozygous Beta-Thalassemia;

(c) Mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy);

(d) Neuroblastoma;

(e) Multiple Myeloma, Stage II or Stage III;

(f) Germ Cell Tumors (e. g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound;

(g) Aplastic anemia;

(h) Acute leukemia;

(i) Severe combined immunodeficiency, e.g., adenosine deaminase deficiency and idiopathic deficiencies;

(j) Wiskott - Aldrich syndrome;

(k) Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);

(l) Hodgkins' and non-Hodgkins' lymphoma;

(m) Combined immunodeficiency;

(n) Chronic myelogenous leukemia;

(o) Pediatric tumors based upon individual consideration.

(2) Parathyroid TRANSPLANTATION.

(3) 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.

(4) Corneal TRANSPLANTATION (keratoplasty) limited to:

(a) Corneal opacity;

(b) 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;

(c) Corneal ulcer;

(d) Repair of severe lacerations.

(5) Kidney.

b. **IMPLANTATIONS.** The following IMPLANTATIONS are covered by this CONTRACT:

(1) Heart valve IMPLANTATION;

(2) Pseudophakia (intraocular lens) IMPLANTATION;

(3) Penile prosthesis IMPLANTATION;

(4) Urethral sphincter IMPLANTATION;

(5) Artificial breast IMPLANTATION.

(6) pacemaker;

(7) defibrillator;

(8) cochlear as required by Wis. Stat. §632.895 (16); and

(9) any other implant which WPS determines is medically necessary and not experimental.

c. **GRAFTINGS.** The following GRAFTINGS are covered by this CONTRACT:

(1) Bone (non-cosmetic);

(2) Skin (non-cosmetic);

(3) Artery;

(4) Arteriovenous shunt;

(5) Blood vessel limited to blood vessel repair;

(6) Cartilage (non-cosmetic);

(7) Conjunctiva;

(8) Fascia;

(9) Lid margin (non-cosmetic);

(10) Mucosa;

(11) Bronchoplasty;

(12) Coronary bypass;

(13) Mucus membrane;

(14) Muscle;

(15) Nerve;

(16) Pterygium;

(17) Rectal (Thiersch operation);

(18) Sclera;

(19) Tendon;

(20) Vein (bypass).

2. EXCLUSIONS.

a. BENEFITS are not payable for any form of or SERVICES related to TRANSPLANTATION, IMPLANTATION or GRAFTING other than those specifically listed in this subsection. This applies even if MEDICARE pays for any portion of the CHARGES.

b. Examples of procedures that are **not payable**:

(1) heart TRANSPLANTATION;

(2) intestine TRANSPLANTATION;

(3) islet tissue (island of Langerhans-pancreas) TRANSPLANTATION;

(4) liver TRANSPLANTATION;

(5) lung TRANSPLANTATION;

(6) pancreas TRANSPLANTATION;

(7) bladder stimulator (pacemaker) IMPLANTATION;

(8) implantable or portable artificial kidney or other similar device; or

(9) dental implants.

c. All exclusions set forth in section “Exclusions” of this CONTRACT apply to this subsection.

HOME CARE AND HOSPICE CARE SERVICES

Except as otherwise excluded in this CONTRACT, BENEFITS are payable for CHARGES for the SERVICES described in this subsection according to the terms, conditions and provisions of this CONTRACT for each PARTICIPANT receiving such SERVICES on or after his/her EFFECTIVE DATE, provided those SERVICES are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and TREATMENT of the PARTICIPANT, as determined by WPS, and are not paid or payable elsewhere under this CONTRACT.

1. HOME CARE SERVICES.

a. Benefits. This paragraph 1. a. applies only if CHARGES for HOME CARE SERVICES are not covered elsewhere under the CONTRACT. A Department licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the SERVICES. A PARTICIPANT should make sure the agency meets this requirement before SERVICES are provided. BENEFITS are payable for CHARGES for the following SERVICES when MEDICALLY NECESSARY for TREATMENT:

(1) Part time or intermittent home nursing care by or under supervision of a registered nurse;

(2) Part time or intermittent home health aide SERVICES when MEDICALLY NECESSARY as part of the HOME CARE plan. The SERVICES must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;

(3) Physical, respiratory, occupational or speech therapy;

(4) MEDICAL SUPPLIES, prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN required to be administered by a professional provider; laboratory SERVICES by or on behalf of a HOSPITAL, if needed under the HOME CARE plan. These items are covered to the extent they would be if the PARTICIPANT had been hospitalized;

(5) Nutrition counseling provided or supervised by a registered dietician;

(6) Evaluation of the need for a HOME CARE plan by a registered nurse, physician extender or medical social worker. The PARTICIPANT'S attending PHYSICIAN must request or approve this evaluation.

b. Limitations. The following limits apply to HOME CARE SERVICES:

(1) HOME CARE isn't covered unless the PARTICIPANT'S attending PHYSICIAN certifies that: (1) hospitalization or CONFINEMENT in a LICENSED SKILLED NURSING FACILITY would be needed if the PARTICIPANT didn't have HOME CARE; and (2) members of the PARTICIPANT'S IMMEDIATE FAMILY or others living with the PARTICIPANT couldn't give the PARTICIPANT the care and TREATMENT he/she needs without undue hardship;

(2) If the PARTICIPANT was hospitalized just before HOME CARE started, the PARTICIPANT'S PHYSICIAN during his/her HOSPITAL stay must also approve the HOME CARE plan;

(3) BENEFITS are payable for CHARGES for up to 50 HOME CARE visits per CALENDAR YEAR per PARTICIPANT. 50 additional visits per PARTICIPANT per

CALENDAR YEAR may be available if MEDICALLY NECESSARY and approved by WPS.

Each visit by a person providing SERVICES under a HOME CARE plan, evaluating the PARTICIPANT'S need or developing a plan, counts as one visit. Each period of up to four straight hours in a 24-hour period of home health aide SERVICE counts as one HOME CARE visit.

(4) If HOME CARE is covered under two or more health insurance contracts or plans, coverage is payable under only one of them. The same is true if the PARTICIPANT has HOME CARE coverage under this CONTRACT and another source;

(5) The maximum weekly BENEFIT for this coverage won't be more than the weekly CHARGES for SKILLED NURSING CARE in a SKILLED NURSING FACILITY, as determined by WPS.

2. HOSPICE CARE SERVICES.

a. BENEFITS are payable for CHARGES for the following HOSPICE CARE SERVICES:

(1) Part-time or intermittent home nursing care by or under the supervision of a registered nurse;

(2) Part-time or intermittent home health SERVICES when MEDICALLY NECESSARY. Such SERVICES must be under the supervision of a registered nurse or medical social worker and consist solely of care for the PARTICIPANT;

(3) Physical, respiratory, occupational or speech therapy;

(4) MEDICAL SUPPLIES, prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN required to be administered by a professional provider; laboratory SERVICES by or on behalf of a HOSPITAL, to the extent CHARGES would be payable for these items under this CONTRACT if the PARTICIPANT had been hospitalized;

(5) Nutrition counseling provided or supervised by a registered nurse, PHYSICIAN extender or medical social worker, when approved or requested by the attending PHYSICIAN; and

(6) Room and board CHARGES at an WPS approved or MEDICARE certified HOSPICE CARE facility.

CHARGES for weekly HOSPICE CARE SERVICES are payable up to the weekly CHARGES for SKILLED NURSING CARE provided in an EXTENDED CARE FACILITY, as determined by WPS.

b. LIMITATIONS FOR HOSPICE CARE SERVICES. BENEFITS for HOSPICE CARE SERVICES are limited as follows:

(1) HOSPICE CARE is not covered unless the PARTICIPANT'S attending PHYSICIAN certifies that: (a) hospitalization or CONFINEMENT would otherwise be required; (b) necessary care and TREATMENT are not available from members of the PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT; and (c) the PARTICIPANT is terminally ill with a life expectancy of six months or less.

(2) CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a MEDICARE certified or WPS approved HOSPICE CARE facility.

CHARGES are payable for HOSPICE CARE SERVICES provided in a PARTICIPANT'S home up to 80 HOSPICE CARE visits within any six month period.

Up to four consecutive hours of HOSPICE CARE SERVICES in a PARTICIPANT'S home is considered as one HOSPICE CARE visit.

When BENEFITS are payable under both this HOSPICE CARE BENEFIT and the HOME CARE BENEFIT, BENEFITS payable under this paragraph 2. shall reduce any benefits payable under paragraph “1. HOME CARE SERVICES”.

WPS MEDICAL MANAGEMENT PROGRAM

The PARTICIPANT must comply with the terms of this section in order to receive this PLAN'S full BENEFITS. This section does not apply to any PARTICIPANT for whom MEDICARE is the primary payor or for any confinements for pregnancy. Other plan limitations, exclusions and conditions are not affected by this section, and still apply.

PREADMISSION AND CONTINUED STAY CERTIFICATIONS

1. Preadmission Certification.

a. For Non-Emergency Admissions. A PARTICIPANT'S attending PHYSICIAN may recommend that a PARTICIPANT be admitted to a HOSPITAL for: (1) non-emergency surgery; (2) TREATMENT; (3) diagnosis; or (4) tests. If so, the PARTICIPANT or the PARTICIPANT'S family member, PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER on the PARTICIPANT'S behalf must notify WPS' Managed Care Department at its Madison office at least three business days prior to the proposed admission date. The notice must be in writing or given by telephone and provide the following information:

(1) patient information: name; birth date; social security number; phone number; and address;

(2) subscriber information: name; social security number; employer or health plan and their address;

(3) the diagnosis with related symptoms and their duration;

(4) results of: physical exam; lab tests; and x-rays;

(5) the TREATMENT plan for the patient;

(6) PHYSICIAN information: name; tax ID or social security number; phone number; address; and medical specialty;

(7) name, address and phone number of the facility to which the patient will be admitted;

(8) the number of inpatient days the physician feels will be needed;

(9) the proposed admission date; and

(10) the date of any proposed surgery or procedure.

If the PARTICIPANT or the PARTICIPANT'S family member, PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER on the PARTICIPANT'S behalf fails to notify WPS of the proposed hospitalization in advance as required above, benefits otherwise payable for the PARTICIPANT'S CONFINEMENT will be reduced by the amount shown in 3. below.

If the PARTICIPANT, or the PARTICIPANT'S family member, PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER on the PARTICIPANT'S behalf, fails to provide the information listed above to WPS' Managed Care Department at least three business days prior to the proposed admission date, WPS may not be able to complete its certification review prior to the date of the PARTICIPANT'S admission to the HOSPITAL. If WPS' review isn't completed by the date of the PARTICIPANT'S admission to the HOSPITAL

because WPS did not receive the notice in advance as required above, the admission may not be certified as MEDICALLY NECESSARY. No BENEFITS are payable for a PARTICIPANT'S CONFINEMENT in a HOSPITAL or any HOSPITAL days thereof which WPS determines are not MEDICALLY NECESSARY.

The proposed admission will be reviewed by WPS in consultation with the PARTICIPANT'S attending PHYSICIAN, provided the PHYSICIAN is available for such consultation. WPS will determine the number of HOSPITAL days for which BENEFITS for CHARGES for covered expenses will be payable under the PLAN. WPS may certify less than the number of HOSPITAL days proposed by the PHYSICIAN if WPS determines that the number of days proposed are not MEDICALLY NECESSARY. WPS may also determine that the proposed admission is not MEDICALLY NECESSARY for the PARTICIPANT. No BENEFITS are payable for CONFINEMENTS or any HOSPITAL days thereof which WPS determines are not MEDICALLY NECESSARY.

The PARTICIPANT'S attending PHYSICIAN may feel there are extenuating circumstances or additional information not available to WPS which medically justifies the hospitalization and/or additional days of CONFINEMENT. If so, he/she should immediately notify WPS accordingly. WPS will review its decision in light of any such extenuating circumstances and/or additional information. Within one business day of WPS' receipt of such information, WPS will notify the PARTICIPANT, PHYSICIAN and HOSPITAL of any change in its original decision.

After the decision is made, the PARTICIPANT, PHYSICIAN and HOSPITAL will be notified in writing by WPS of its decision. The letter will state whether or not the proposed admission has been certified and, if so, the number of HOSPITAL days certified as being MEDICALLY NECESSARY for the PARTICIPANT.

b. **For Emergency Admissions.** If a PARTICIPANT is admitted to a HOSPITAL on an emergency basis, WPS must be notified in writing or by telephone within two business days after the date of admission, unless circumstances beyond your control prevents the PARTICIPANT from providing such notification. If so, the PARTICIPANT must notify WPS as soon as possible. The PARTICIPANT, or the PARTICIPANT'S family member, PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER on the PARTICIPANT'S behalf, must provide the same information as required for non-emergency admissions. The admission will be reviewed by WPS in consultation with the PHYSICIAN, provided the PHYSICIAN is available for such consultation. WPS will determine the number of MEDICALLY NECESSARY HOSPITAL days for which BENEFITS are payable under the PLAN. WPS may certify less than the number of HOSPITAL days proposed by the PHYSICIAN if WPS determines that the number of days proposed are not MEDICALLY NECESSARY. WPS may also determine that the proposed admission is not MEDICALLY NECESSARY for the PARTICIPANT. After the decision is made, WPS will notify in writing the PARTICIPANT, PHYSICIAN and HOSPITAL of its decision. No benefits are payable for CONFINEMENT in a HOSPITAL or any HOSPITAL days thereof which WPS determines are not MEDICALLY NECESSARY.

If the PARTICIPANT, or the PARTICIPANT'S family member, PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER on the PARTICIPANT'S behalf, fails to notify WPS of the emergency admission as required above, BENEFITS otherwise payable for the PARTICIPANT'S CONFINEMENT will be reduced by the amount shown in 3. below.

The PARTICIPANT'S attending PHYSICIAN may feel there are extenuating circumstances or additional information not available to WPS which medically justifies the hospitalization and/or additional days of CONFINEMENT. If so, he/she should immediately notify WPS accordingly. WPS will review its decision in light of any such extenuating circumstances and/or additional information. Within one business day of WPS' receipt of such

information, WPS will notify the PARTICIPANT, PHYSICIAN and HOSPITAL of any change in its original decision.

2. Continued Stay Certification.

Prior to expiration of the total number of MEDICALLY NECESSARY HOSPITAL days originally certified by WPS for a PARTICIPANT'S emergency or non-emergency admission, the PARTICIPANT'S attending PHYSICIAN or the HOSPITAL utilization review staff will be contacted by WPS by telephone to determine if: (a) the patient has been discharged; or (b) WPS needs to review the MEDICAL NECESSITY of the PARTICIPANT'S continued hospitalization beyond the number of HOSPITAL days originally certified by WPS as being MEDICALLY NECESSARY. WPS' certification of those additional days of CONFINEMENT review will be performed by WPS in the same manner as its review of the PARTICIPANT'S original HOSPITAL admission. Then WPS will make a decision on the certification of the MEDICAL NECESSITY of the number of additional days of CONFINEMENT, if any. Such continued stay reviews may be performed by WPS periodically until: (a) discharge occurs; or (b) WPS determines that additional days of CONFINEMENT for that PARTICIPANT may no longer be certified as MEDICALLY NECESSARY.

If the PARTICIPANT remains CONFINED in the HOSPITAL beyond the number of days certified by WPS as being MEDICALLY NECESSARY, BENEFITS are not payable for INPATIENT HOSPITAL SERVICES and related HEALTH CARE SERVICES provided to that PARTICIPANT which WPS determines are not MEDICALLY NECESSARY, in accordance with paragraph 3. below.

3. Payment of BENEFITS.

If the PARTICIPANT, or the PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER on the PARTICIPANT'S behalf, received WPS' preadmission certification, BENEFITS for CHARGES for INPATIENT CONFINEMENTS are payable as described under the PLAN. However:

a. If a PARTICIPANT'S non-emergency admission occurs without WPS being notified in advance in accordance with paragraph 1. a. above, BENEFITS payable for CHARGES for covered expenses for INPATIENT HOSPITAL SERVICES and related HEALTH CARE SERVICES provided to that PARTICIPANT, which WPS determines are MEDICALLY NECESSARY, will be reduced by $100 for that CONFINEMENT. No BENEFITS are payable for INPATIENT HOSPITAL SERVICES and related HEALTH CARE SERVICES which WPS determines are not MEDICALLY NECESSARY.

b. If a PARTICIPANT'S emergency admission occurs without WPS being notified in accordance with paragraph 1. b. above, BENEFITS payable for CHARGES for covered expenses for INPATIENT HOSPITAL SERVICES and related HEALTH CARE SERVICES provided to that PARTICIPANT, which WPS determines are MEDICALLY NECESSARY, will be reduced by $100 for that CONFINEMENT. No BENEFITS are payable for INPATIENT HOSPITAL SERVICES and related HEALTH CARE SERVICES which WPS determines are not MEDICALLY NECESSARY.

c. If a PARTICIPANT remains confined in a HOSPITAL beyond the number of days certified by WPS as being MEDICALLY NECESSARY in accordance with paragraph 2. above, BENEFITS are not payable for INPATIENT HOSPITAL SERVICES and related HEALTH CARE SERVICES provided to that PARTICIPANT which WPS determines are not MEDICALLY NECESSARY.

A PARTICIPANT may receive INPATIENT HOSPITAL SERVICES and related HEALTH CARE SERVICES after WPS originally determines such expenses are not MEDICALLY NECESSARY. A PARTICIPANT may also receive INPATIENT HOSPITAL SERVICES and related HEALTH CARE SERVICES during HOSPITAL days which exceed the number of HOSPITAL days certified by WPS as being MEDICALLY NECESSARY. Such expenses may later be eligible for BENEFITS under the

PLAN if WPS later determines on the basis of new information that such expenses are MEDICALLY NECESSARY for the PARTICIPANT.

PRENATAL AND MATERNITY CARE NOTIFICATION

Maternity admissions are not subject to the preadmission and continued stay certification requirements described above. However, if a PARTICIPANT is pregnant, WPS requests that the PARTICIPANT also notifies WPS:

1. after the PARTICIPANT'S first prenatal visit, but no later than the PARTICIPANT'S 13th week of pregnancy; and

2. within 24 hours or the first business day following the date of the PARTICIPANT'S delivery.

Although the PARTICIPANT'S failure to provide such notice won't reduce BENEFITS otherwise payable for such HEALTH CARE SERVICES, this notice to WPS will allow WPS to work with the PARTICIPANT and the PARTICIPANT'S PHYSICIAN during the pregnancy to help coordinate MEDICALLY NECESSARY HEALTH CARE SERVICES and provide high-risk screening and health information.

DISEASE CASE MANAGEMENT

Disease case management (DCM) is a proactive approach to health care designed to prevent long-term and unnecessary complications of chronic disease through education, TREATMENT, and appropriate care. WPS' DCM program partners chronically-ill PARTICIPANTS and their HEALTH CARE PROVIDERS with WPS Disease Case Management nurses to gain control over diseases such as diabetes, asthma, congestive heart failure, coronary artery disease, depression, addictive disorders, high-risk maternity, hypertension, and high cholesterol.

WPS identifies potential disease case management PARTICIPANTS either through our claims processing system or by referral from a number of sources, for example, a family member or HEALTH CARE PROVIDER. Once a PARTICIPANT is identified, one of WPS' nurses will telephone that PARTICIPANT to go through a clinical assessment and determine if the PARTICIPANT is interested in the program.

Education and support follow the initial assessment by phone or mail. WPS DCM nurses routinely check on health status, remind PARTICIPANTS about medications, share new information about a disease or TREATMENT, or follow up after office visits to ensure that the PARTICIPANT understands their PHYSICIAN'S instructions.

MEDICARE PLUS

Medicare Plus is designed to supplement, not duplicate, BENEFITS available under the federal MEDICARE program. It is designed for ANNUITANTS and is not available to active EMPLOYEES, their spouses or DEPENDENTS.

See the booklet "State Medicare Plus Health Care Benefit Plan" for a description of BENEFITS and other provisions of the PLAN. Additional information may be obtained by referring to "Your MEDICARE Handbook" published by the Social Security Administration.

1. Unless you are an active (non-retired) state EMPLOYEE, all family members must enroll in MEDICARE (both Part A - HOSPITAL and Part B - Medical) when first eligible. Otherwise, state group health coverage is subject to cancellation without the right of reinstatement. This requirement is deferred for active EMPLOYEES (and their DEPENDENTS) until the EMPLOYEE'S termination of state employment.

2. Those family members not eligible for MEDICARE will continue their Standard or SMP coverage.

3. Medicare Plus will provide uninterrupted coverage from Standard coverage or SMP.

4. Medicare Plus provides reimbursement for all DEDUCTIBLES under MEDICARE Part A (Hospitalization) and MEDICARE Part B (Medical) if you have incurred at least that DEDUCTIBLE amount in covered expenses during the CALENDAR YEAR.

5. Medicare Plus provides payment for prescribed or recommended SERVICES and SUPPLIES which may not be covered or fully covered by MEDICARE.

EXCLUSIONS

Except as otherwise specifically provided, this CONTRACT provides no BENEFITS for:

1. CUSTODIAL CARE or rest cures, wherever furnished, and care in custodial or similar institutions, a health resort, spa or sanitarium. This applies even if MEDICARE pays for any portion of the CHARGES.

2. Physical examinations or health checkups for informational purposes requested by third parties. Examples: physical exams required by schools, summer camp, employment, marriage, insurance, sports, etc.

3. SERVICES of a blood donor.

4. HEALTH CARE SERVICES for cosmetic or beautifying purposes, except to correct CONGENITAL bodily disorders or conditions or when MEDICALLY NECESSARY for TREATMENT of an ILLNESS or accidental INJURY.

5. Preparation, fitting or purchase of eye glasses or contact lenses, except as specifically stated in the PLAN; vision therapy, including orthoptic therapy and pleoptic therapy; or eye refractive surgery; hearing aids or examinations for their prescription, except as specifically covered under the PLAN.

6. TREATMENT of corns and calluses of the feet, toenails (except for complete removal), overgrowth of the skin of the feet, unless prescribed by a PHYSICIAN who is treating the PARTICIPANT for a metabolic or peripheral disease.

7. SERVICES of a dentist, including all orthodontic SERVICES, or SERVICES provided in the examination, repair or replacement of teeth, or in the extraction of teeth, dental implants, or TREATMENT for Temporomandibular Joint Disease (TMJ) other than recognized radical ORAL SURGERY, except as expressly provided in this CONTRACT. An accident caused by chewing is not considered an INJURY.

8. HEALTH CARE SERVICES:

- **a.** that would be furnished to a PARTICIPANT without charge;
- **b.** which a PARTICIPANT would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or
- **c.** Which a PARTICIPANT 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.

9. HEALTH CARE SERVICES for any INJURY or ILLNESS eligible for coverage, or for which a PARTICIPANT receives, or which is the subject of, any award or settlement under a Worker's Compensation Act or any EMPLOYER liability law.

10. HEALTH CARE SERVICES for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of the 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.

11. HEALTH CARE SERVICES furnished by the U.S. Veterans Administration, except for such TREATMENT, SERVICES and supplies for which under this CONTRACT, this CONTRACT is the

primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.

12. HEALTH CARE SERVICES available from OTHER COVERAGE. Then, BENEFITS will be limited to the CHARGES for TREATMENT, SERVICES and supplies, less payments available from OTHER COVERAGE. Together, the total BENEFITS payable may not exceed the incurred CHARGES. In computing allowances available, the primary carrier according to Wis. Adm. Code § 3.40 will provide the full BENEFITS payable under its CONTRACT, with the other carrier processing the remainder of those CHARGES. However, when MEDICARE is primary, payment of BENEFITS is limited to the amount computed without coordination of BENEFITS, less the MEDICARE payments. The MEDICARE allowed amount on assigned claims is considered the CHARGE; on unassigned claims, the CHARGE is the MEDICARE limiting CHARGE amount.

If the PARTICIPANT is not actually enrolled in the voluntary medical insurance portion of MEDICARE when it is first available, the member's BENEFITS are limited to the extent they are entitled, or would be entitled if enrolled for MEDICARE BENEFITS.

13. Major medical BENEFITS for HEALTH CARE SERVICES that are provided under the STANDARD PLAN basic coverage either in their entirety or partially because of allowance limitations, COINSURANCE or DEDUCTIBLES.

14. Any BENEFITS under sections "Benefit Provisions", if the PARTICIPANT is eligible to enroll in MEDICARE. This exclusion is not applicable until the PARTICIPANT'S termination of employment with the State of Wisconsin.

15. PROFESSIONAL SERVICES not provided by a PHYSICIAN or any health care provider listed in the definition of PROFESSIONAL SERVICES in section "Definitions".

16. HEALTH CARE SERVICES which are not MEDICALLY NECESSARY or which aren't appropriate for the TREATMENT of an ILLNESS or INJURY, as determined by WPS.

17. Reversal of sterilization.

18. HEALTH CARE SERVICES which are EXPERIMENTAL or INVESTIGATIVE in nature, except for prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN and required to be administered by a professional provider described in Wis. Stats. § 632.895 (9) for TREATMENT of HIV.

19. HEALTH CARE SERVICES for, or leading to, sex transformation surgery and sex hormones related to such TREATMENT.

20. 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.

21. HEALTH CARE SERVICES provided by a midwife, except when provided in a clinic or hospital setting.

22. Food received on an OUTPATIENT basis or food supplements.

23. Housekeeping, shopping or meal preparation SERVICES.

24. HEALTH CARE SERVICES in connection with obesity, weight reduction or dietetic control, except for morbid obesity and disease etiology.

25. Retin-A, Minoxidil, Rogaine or their medical equivalent in the topical application form, unless MEDICALLY NECESSARY.

26. HEALTH CARE SERVICES used in educational or vocational training or testing, except as specifically stated in the PLAN.

27. HEALTH CARE SERVICES in connection with any ILLNESS or INJURY caused by a PARTICIPANT'S: (a) engaging in an illegal occupation; or (b) commission of, or an attempt to commit, a felony.

28. Motor vehicles; lifts for wheelchairs and scooters; and stair lifts.

29. HEALTH CARE SERVICES for which the PARTICIPANT has no obligation to pay.

30. HEALTH CARE SERVICES rendered by a member of a PARTICIPANT'S IMMEDIATE FAMILY or a person who resides in the PARTICIPANT'S home.

31. Routine periodic maintenance of covered DURABLE MEDICAL EQUIPMENT, such as, replacement batteries.

32. HEALTH CARE SERVICES for the purpose of smoking cessation.

33. HEALTH CARE SERVICES determined to be MAINTENANCE CARE by WPS.

34. Over-the-counter drugs.

35. Prescription drugs and BIOLOGICALS prescribed in writing by a PHYSICIAN for TREATMENT of an ILLNESS or INJURY and dispensed by a licensed pharmacist. For purposes of this exclusion, "prescription drug" means drugs that are dispensed by a written prescription from a PHYSICIAN, under Federal law, approved for human use by the Food and Drug Administration and dispensed by a pharmacist.

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

37. Charges for injectable medications, except as specifically stated in the PLAN.

38. HEALTH CARE SERVICES to the extent the PARTICIPANT is eligible for MEDICARE BENEFITS, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if MEDICARE is the primary payor.

39. That portion of the amount billed for a health care service covered under the Plan that exceeds WPS' determination of the CHARGE for such health care service.

40. Supportive care.

41. Telephone, computer or internet consultations between a member and any HEALTH CARE PROVIDER.

42. Indirect services provided by health care providers for services such as, but are not limited to: creation of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; and reviewing quality assurance data.

43. Orthopedic shoes.

44. Health care services for treatment of sexual dysfunction, including impotence, regardless of the cause of the dysfunction. This includes: (a) surgical services; (b) devices (c) drugs for, or used in connection with, sexual dysfunction; (d) penile implants and (e) sex therapy.

PREAUTHORIZATION

This section describes the types of health care services that should be preauthorized but are not required to be prior approved.

BENEFITS are not payable for HEALTH CARE SERVICES that are EXPERIMENTAL, INVESTIGATIVE or not MEDICALLY NECESSARY, as determined by WPS. The types of procedures or SERVICES that may fall into this category, but not limited to these, are:

1. New medical or biomedical technology;

2. Methods of TREATMENT by diet or exercise;

3. New surgical methods or techniques;

4. Acupuncture or similar methods;

5. Transplants of body organs, unless specifically covered under section “Benefit Provisions” of this CONTRACT;

6. Sleep studies;

7. Sclerotherapy;

8. Pain injections such as epidural injections, facet injections or trigger point injections; and

9. Low back surgery and SERVICES of orthopedists and neurosurgeons associated directly or indirectly with the PLAN for PARTICIPANTS with a history of low back pain and who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty services.

A PARTICIPANT may ask WPS whether or not a HEALTH CARE SERVICE will be covered and how much in BENEFITS will be paid. If a HEALTH CARE SERVICE is preauthorized by WPS, no payment can be made unless the PARTICIPANT'S coverage is in effect at the time the HEALTH CARE SERVICE is provided to the PARTICIPANT.

If a PARTICIPANT does not use this preauthorization procedure, WPS may decide that the HEALTH CARE SERVICE is EXPERIMENTAL, INVESTIGATIVE or not MEDICALLY NECESSARY. No payment can then be made for the HEALTH CARE SERVICE or any related HEALTH CARE SERVICE.

If a PARTICIPANT or his/her PHYSICIAN disagrees with WPS’ decision, the PARTICIPANT may appeal that decision by submitting documentation to WPS from the treating PHYSICIAN as to the medical value or effectiveness of the HEALTH CARE SERVICE. The appeal will be reviewed by practicing PHYSICIANS and, if necessary, an appropriate committee of WPS. The decision made at that time will be final.

INDIVIDUAL TERMINATION OF COVERAGE

1. A PARTICIPANT'S coverage shall terminate at the end of the month on the earliest of the following dates:

a. The EFFECTIVE DATE of change to another health care plan through the BOARD approved enrollment process.

b. The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. Pursuant to Federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the PLAN'S requirement for the amount that must be paid. However, the PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period.

c. The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage, while on a leave of absence or LAYOFF, as required by state and federal law.

d. The end of the month in which a notice of cancellation of coverage or sick leave escrow application is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT or CONTINUANT, or a later date as specified on the cancellation of coverage notice or sick leave escrow application.

e. The definition of PARTICIPANT no longer applies (such as a dependent child's marriage, divorced spouse, end of a domestic partnership, etc.). If FAMILY COVERAGE remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification of continuation of coverage rights occurs. The EMPLOYER may collect PREMIUM retroactively from the SUBSCRIBER if the divorce was not reported in a timely manner and there were no other eligible DEPENDENTS for FAMILY COVERAGE to remain in effect.

f. The expiration of the continuation period for which the PARTICIPANT is allowed to continue under paragraph 4. below, of this subsection.

g. The EFFECTIVE DATE of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any pre-existing condition of PARTICIPANT who continues under paragraph 4. of this section.

h. The earliest date Federal or State continuation provisions permit termination of coverage for any reason.

i. The end of the month in which the SUBSCRIBER terminates employment.

2. No refund of any PREMIUM may be made unless the EMPLOYER, or DEPARTMENT if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month for which PREMIUM has been collected or deducted. Except, for State of Wisconsin EMPLOYEES, when coverage ends by reason of termination of employment, then refunds shall be made back to the end of the month in which employment terminates.

3. Except when a PARTICIPANT'S coverage terminates because of cancellation or non-payment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if confined as an INPATIENT, 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.

4. **a.** Except when coverage is cancelled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the EMPLOYER is not notified of the PARTICIPANT'S loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the EMPLOYER notice, whichever is later. Application must be post-marked within 60 days of the date the PARTICIPANT is notified of the right to continue or 60 days from the date coverage ceases, whichever is later. WPS shall bill the continuing PARTICIPANT directly for the required PREMIUMS. WPS may not apply an administrative surcharge to the PREMIUM, even if otherwise permitted under state or federal law.

b. Such PARTICIPANT may also elect to convert to individual coverage, without underwriting, if application is made directly to the PLAN within 30 days after termination of group coverage as provided under Wis. Stat. 632.897. The PARTICIPANT shall be eligible to apply for the direct pay conversion contract then being issued provided coverage is continuous and the PREMIUMS then in effect for the conversion contract are paid without lapse. The PLAN must notify a PARTICIPANT at least 60 days prior to loss of eligibility for COBRA coverage and will also notify the PARTICIPANT of other available options including the availability of conversion coverage and HIRSP. This does not include termination of coverage due to non-payment of PREMIUM. The right to a conversion contract will also be offered when the PARTICIPANT reaches the maximum length of continuation for group coverage.

5. Children born or adopted while the parent is continuing group coverage may be covered for the remainder of the parent's period of continuation. A PARTICIPANT who has SINGLE COVERAGE must elect FAMILY COVERAGE within 60 days of the birth or adoption in order for the child to be covered. The PLAN will automatically treat the child as a qualified DEPENDENT as required by COBRA and provide any required notice of COBRA rights.

6. No person other than a PARTICIPANT is eligible for health BENEFITS. The SUBSCRIBER'S rights to group health 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 coverage is available and is limited to the STANDARD PLAN.

Change to an alternate 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.

7. In situations where a PARTICIPANT in an alternate health plan 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 PHYSICIAN, disenrollment efforts may be initiated by the PLAN or the BOARD. The SUBSCRIBER'S disenrollment is the beginning of the month following completion of the grievance process and approval of the BOARD. Coverage will be transferred to the STANDARD PLAN, with options to enroll in alternate health care plans during subsequent dual-choice enrollment periods. Re-enrollment in the alternate plans is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

GENERAL CONDITIONS

BENEFITS are available in accordance with the terms, conditions and provisions of this CONTRACT, including:

1. No provision of this CONTRACT shall interfere with the professional relationship between a PARTICIPANT and PHYSICIAN.

2. If a PARTICIPANT remains in an institution after being advised by the attending PHYSICIAN that further CONFINEMENT is medically unnecessary, the PARTICIPANT will be solely responsible to the institution for all expenses incurred after being so advised. WPS or the BOARD may at any time request the attending PHYSICIAN to certify that further CONFINEMENT is MEDICALLY NECESSARY.

3. Each PARTICIPANT is free to select and/or discharge a PHYSICIAN. A PHYSICIAN is free to provide SERVICE or not, in accordance with the custom in private practice of medicine. Nothing in this CONTRACT obligates WPS or the BOARD to provide a PHYSICIAN to treat any PARTICIPANT.

4. Each PARTICIPANT agrees to conform to the rules and regulations of the institution in which he/she is an INPATIENT, including those rules governing admissions and types and scope of SERVICES furnished by the institution.

5. As a condition of entitlement to receive BENEFITS, each PARTICIPANT authorizes any person or institution to furnish to WPS all medical and surgical reports and other information as WPS may request.

6. WPS and the BOARD each have the right and opportunity to have a PARTICIPANT examined by PHYSICIANS of their choice when and as often as they may reasonably require.

7. The PARTICIPANT'S identification card must be presented, or the fact of the PARTICIPANTS participation under this CONTRACT be made known, to the provider when the PARTICIPANT requests care or SERVICES.

8. If a PARTICIPANT fails to comply with G. above, then written notice of the commencement of TREATMENT or CONFINEMENT must be given to WPS within 30 days after the commencement of TREATMENT or CONFINEMENT. Failure to give that notice will not invalidate or reduce any claim if it is shown that notice was given as soon as was reasonably possible. However, no BENEFITS will be paid for CHARGES incurred in any CALENDAR YEAR unless a claim for those CHARGES is received by WPS within 24 months from the date the SERVICE was rendered.

9. Each PARTICIPANT agrees to reimburse WPS or the BOARD for all payments made for BENEFITS to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the PARTICIPANT by WPS or the BOARD. At the option of WPS or the BOARD, BENEFITS for future CHARGES may be reduced by WPS as a set off toward reimbursement. Acceptance of PREMIUMS or paying BENEFITS for CHARGES will not constitute a waiver of the rights of WPS or the BOARD to enforce these provisions in the future.

10. Each PARTICIPANT agrees to use a medical claim form when submitting claims for medical BENEFITS that are not submitted to WPS by the provider. Only itemized bills, statements acknowledging actual receipt of payment, or similar receipts may serve as proof of claim. Each must be an official document from the provider. Cash register receipts that are not itemized or do not clearly identify the provider, canceled checks, custom order forms and balance due statements alone are NOT acceptable as proof of claim.

Each itemized bill statement or receipt must include the patient's name, patient's WPS identification number, provider's name, provider's address, date(s) of SERVICE, diagnosis and diagnostic code, procedure code, and CHARGE for each date of SERVICE and is an official document from the provider.

For medical claims incurred outside of the United States, the PARTICIPANT, must obtain information on foreign currency exchange rates at the time CHARGES were incurred and an English language itemized billing to facilitate claim processing.

11. WPS will, at its option, pay BENEFITS either to the provider of SERVICES or to the PARTICIPANT.

12. Each PARTICIPANT agrees that the BOARD is subrogated to the PARTICIPANT'S rights to damages for an ILLNESS or INJURY caused by any act or omission of any third person to the extent of BENEFITS.

13. A PARTICIPANT shall not commence any action to recover any BENEFITS or enforce any rights under this CONTRACT until 60 calendar days have elapsed since written notice of claim was given by the PARTICIPANT to WPS, nor will any action be brought more than three years after the SERVICES have been provided.

14. Any provisions of the CONTRACT which may be prohibited by law are void, but will not impair any other provision.

15. WPS or a PARTICIPANT'S PHYSICIAN may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment program 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 incurred for SERVICES provided under the recommended TREATMENT will probably be less.

If WPS agrees to the PHYSICIAN'S recommendation or if the PARTICIPANT or his/her authorized representative and the attending PHYSICIAN agree to WPS' recommendation, the recommended TREATMENT will be provided as soon as it is available.

BENEFITS payable for the CHARGES incurred for such SERVICES shall be paid according to the terms and conditions of this CONTRACT. If the recommended TREATMENT includes SERVICES for which BENEFITS are not otherwise payable, payment of BENEFITS will be as determined by WPS.

16. WPS may recommend that an INPATIENT be transferred to another institution if it appears that:

a. the other institution is able to provide the necessary medical care; and

b. the physical transfer would not jeopardize the PARTICIPANT'S health or adversely affect the current course of TREATMENT; and

c. the CHARGES incurred at the succeeding institution will probably be less than those CHARGES at the prior institution.

If the PARTICIPANT or his/her authorized representative and the attending PHYSICIAN agree to the transfer, the transfer will take place as soon as bed space is available.

17. The CONTRACT contains the following provision:

"Disputes as to CHARGES shall be referred, on a timely basis, to WPS who shall actively attempt to settle the dispute with the provider in a reasonable time frame.

If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT shall contact the DEPARTMENT or WPS within 14 DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two BUSINESS DAYS of WPS becoming aware of a lawsuit, WPS shall notify the DEPARTMENT about the lawsuit. The DEPARTMENT shall advise WPS to either to attempt to resolve the lawsuit or hire an attorney to undertake the defense of such a lawsuit for the PARTICIPANT. WPS shall hire outside legal counsel to represent that PARTICIPANT in any lawsuit involving WPS' determination of the CHARGE for a covered health care service under the HEALTH BENEFIT PLAN and to undertake the defense of such a lawsuit for the PARTICIPANT or take such other measures as WPS deems necessary to resolve the dispute. However, it is understood and agreed that WPS shall not hire outside legal counsel to represent that PARTICIPANT and undertake the defense of any such lawsuit or take any other measures to protect the PARTICIPANT if the PARTICIPANT agrees to accept responsibility for any costs in excess of the CHARGE determined by WPS."

While in the great majority of cases PHYSICIANS accept the WPS payment as reasonable, a PARTICIPANT may on occasion be asked by the PHYSICIAN to agree verbally or to sign an agreement accepting the responsibility for any CHARGES in excess of those paid by WPS. PARTICIPANTS should understand that such a verbal or written agreement about fees with the provider will forfeit full protection under the CONTRACT.

CHARGES in excess of what WPS determined to be "reasonable" will appear on your Explanation of Benefits (EOB) statement.

If your PHYSICIAN or HOSPITAL bills you for any remaining balance in excess of the reasonable amount, you should:

a. send all bills you may receive for balances above the reasonable payments made by WPS to the WPS office immediately. Continue sending WPS all such bills you receive. This is the means by which WPS is notified that you are continuing to be billed for the remaining balance.

b. call WPS immediately if you receive notice that such a balance has been referred for legal action or to a credit or collection agency (see CONTRACT language above).

You are not responsible for paying CHARGES in excess of what WPS determines as reasonable unless you have made an agreement with the service provider to accept this liability.

18. In addition to the continuity of care provisions under Wis. Stat. § 609.24, the following provider guarantee provision applies. HEALTH CARE PROVIDERS listed on any of the PLAN'S publications of providers, including subcontracted providers, are either under contract and available as specified in such publications for all of the ensuing calendar year or the PLAN will pay charges for benefits on a fee-for-service basis. Fee-for-service basis means the usual and customary charges the PLAN is able to negotiate with the HEALTH CARE PROVIDER while the SUBSCRIBER is held harmless and indemnified. The intent of this provision is to allow patients of PLAN HEALTH CARE PROVIDERS to continue appropriate access to any PLAN HEALTH CARE PROVIDER until the PARTICIPANT is able to change PLANS through the next dual-choice enrollment. This applies in the event a HEALTH CARE PROVIDER or provider group terminates its contract with the PLAN, except that loss of physicians due to normal attrition (death, retirement, a move from the service area) or as a result of a formal disciplinary action relating to quality of care shall not require fee-

for-service payment. HEALTH CARE PROVIDERS also agree to accept new patients unless specifically indicated otherwise. When HEALTH CARE PROVIDERS terminate their contractual relationship, SUBSCRIBERS must be notified by the PLAN prior to the dual-choice enrollment period. The PLAN shall keep a record of this notification mailing and shall provide documentation, by SUBSCRIBER and indicating the mailing address used, upon the DEPARTMENT'S request.

CLAIM DETERMINATION AND GRIEVANCE PROCEDURE

WPS will send the PARTICIPANT written notice regarding the claim within 30 days of receiving the claim, unless special circumstances require more time. This notice explains the reason(s) for payment or non-payment of a claim. If a claim is denied because of incomplete information, the notice indicates what additional information is needed. The PARTICIPANT may contact WPS Member Service department for more details of the decision.

If any PARTICIPANT has a problem or complaint relating to a BENEFIT determination, he/she should contact WPS. WPS will assist the PARTICIPANT in trying to resolve the matter on an informal basis, and may initiate a Claim Review of the BENEFIT determination. If the PARTICIPANT wishes, he/she may omit this step and immediately file a formal GRIEVANCE.

Claim Review

A claim review may be done only when a PARTICIPANT requests a review of denied BENEFITS. When a claim review has been completed, and the decision is to uphold the denial of BENEFITS, the PARTICIPANT will receive written notification as to the specific reason(s) for the continued denial of BENEFITS and of his/her right to file a GRIEVANCE.

EXPEDITED GRIEVANCE

Appeals related to an urgent health concern (i.e., life threatening), will be handled within 72 hours of WPS' receipt of the GRIEVANCE.

Formal GRIEVANCE

To submit a GRIEVANCE, the PARTICIPANT (or the PARTICIPANT'S authorized representative) must submit it in writing to WPS and identify it as a GRIEVANCE. In addition, the PARTICIPANT should also include the following information:

1. The date of service, the patient's name, amount and any other identifying information such as claim number or health care provider, as shown on the denial; and

2. Any other pertinent information such as the identification number, patient's name, date and place of service, and reason for requesting review.

PARTICIPANTS have three years after receiving our initial notice of denial or partial denial of your claim to file a grievance.

Except for an EXPEDITED GRIEVANCE, WPS will acknowledge receipt of the GRIEVANCE within 5 business days of receipt. WPS will inform the PARTICIPANT, in writing, of when the GRIEVANCE will be heard by the GRIEVANCE committee at least seven (7) calendar days prior to the date of the meeting.

The PARTICIPANT (or the PARTICIPANT'S authorized representative) will have the right to appear in person before the GRIEVANCE committee or by teleconference to present written or oral information. If the PARTICIPANT (or the PARTICIPANT'S authorized representative) chooses to participate in the GRIEVANCE committee hearing, WPS must be notified no less than four (4) business days prior to the date of the meeting.

WPS will review the GRIEVANCE. WPS will provide a written decision, including reasons, within 30 calendar days of receiving the GRIEVANCE. If special circumstances require a longer review period, before the 30 calendar day period has expired, WPS will notify the PARTICIPANT that an additional 30 calendar days will be needed to review the GRIEVANCE citing the reason additional time is needed and when resolution will be expected.

RIGHTS AFTER GRIEVANCE

There are potentially two avenues of further review available to the PARTICIPANT after WPS' final GRIEVANCE decision.

1. Group Insurance Board Administrative Review Process (ETF Chapter 11, Wis. Administrative Code)

WPS' final GRIEVANCE decision may be reviewed by the Department of Employee Trust Funds provided the written request for the review is received by the Department within 60 days after WPS' final GRIEVANCE decision letter is sent to the PARTICIPANT. Decisions not timely appealed to the Department are final. Send requests to:

Department of Employee Trust Funds
Attn: Quality Assurance Services Bureau
801 West Badger Road
P.O. Box 7931
Madison, WI 53707-7931

2. External Review by an Independent Review Organization

You can request an independent review if:

a. you were denied coverage for a HEALTH CARE SERVICE because WPS has determined that the HEALTH CARE SERVICE is not MEDICALLY NECESSARY;

b. you were denied coverage for a HEALTH CARE SERVICE because WPS has determined that the HEALTH CARE SERVICE is EXPERIMENTAL or INVESTIGATIVE;

c. you disagree with WPS' determination regarding the diagnosis and level of service for TREATMENT of autism; or

d. you disagree with WPS' determination denying or terminating TREATMENT or payment for TREATMENT on the basis of a preexisting condition exclusion.

To qualify for EXTERNAL REVIEW, the PARTICIPANT'S claim must involve one of the determinations stated above.

In either case, the TREATMENT must cost more than the amount specified by the OCI or the Patient Protection and Affordable Care Act in order to qualify for EXTERNAL REVIEW.

If the PARTICIPANT wishes to pursue EXTERNAL REVIEW instead of a review by the Department of Employee Trust Funds, the PARTICIPANT or the PARTICIPANT'S authorized representative must notify WPS' Appeal Department in writing at the following address:

WPS Health Insurance
Attention: IRO Coordinator
P.O. Box 7458
Madison, WI 53708

WPS must receive the request within four months of the date of the PARTICIPANT'S GRIEVANCE decision letter.

If a PARTICIPANT or his/her authorized representative wish to file a request for an independent review, the PARTICIPANT'S request must be submitted in writing to the address listed above and received within four months of the decision date of the PARTICIPANT'S grievance. Within five days of WPS' receipt of his/her request, an accredited IRO will be assigned to the PARTICIPANT'S case through an unbiased random selection process. The assigned IRO will send the PARTICIPANT a notice of acceptance within one business day of receipt, advising the PARTICIPANT of his/her right to submit additional information within ten business days of his/her receipt of the notice from the IRO. The assigned IRO will also deliver a notice of the final external review decision in writing to the PARTICIPANT and WPS within 45 calendar days of their receipt of the request. A decision made by an IRO is binding for both the PARTICIPANT and the PLAN with the exception of pre-existing condition exclusions. The PARTICIPANT is not responsible for the costs associated to the IRO. In addition, some of the information a PARTICIPANT provides may be shared with appropriate regulatory authorities.

There are certain circumstances in which the PARTICIPANT may be able to skip the GRIEVANCE process and proceed directly to EXTERNAL REVIEW. Those circumstances are as follow:

a. WPS agrees to proceed directly to EXTERNAL REVIEW, or

b. The PARTICIPANT'S situation requires an EXPEDITED REVIEW.

If the PARTICIPANT'S situation requires an EXPEDITED REVIEW:

a. WPS will notify the INDEPENDENT REVIEW ORGANIZATION and the Department of Employee Trust Funds within one day and send them the PARTICIPANT'S information.

b. The INDEPENDENT REVIEW ORGANIZATION will review the material, normally within two business days, and will request additional information, if necessary. WPS will have two business days to respond to this request.

c. Once the INDEPENDENT REVIEW ORGANIZATION has all the necessary information, it will render a decision, normally within 72 hours.

The decision of the INDEPENDENT REVIEW ORGANIZATION is binding to both WPS and the PARTICIPANT as per contract. Once the INDEPENDENT REVIEW ORGANIZATION decision is issued, the PARTICIPANT has no further rights to review by the Department of Employee Trust Funds.

The PARTICIPANT cannot request a review of WPS' final appeal decision by both an INDEPENDENT REVIEW ORGANIZATION and the Department of Employee Trust Funds simultaneously. Once an INDEPENDENT REVIEW ORGANIZATION has begun the process to review a case, the DEPARTMENT will suspend its process. The INDEPENDENT REVIEW ORGANIZATION'S decision is binding on all parties and cannot be further appealed. If the INDEPENDENT REVIEW ORGANIZATION rejects the request for review of the ADVERSE DETERMINATION involving MEDICAL NECESSITY or EXPERIMENTAL TREATMENT denial on the ground of jurisdiction, then the DEPARTMENT will continue its process.

MISCELLANEOUS INFORMATION

How To File A Claim

1. Present your WPS identification card to the PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER when a covered SERVICE is received. The HEALTH CARE PROVIDER may submit the claim directly to WPS or MEDICARE. If the HEALTH CARE PROVIDER declines to submit the claim, you should obtain an itemized billing statement and forward it together with your identification numbers to WPS for processing.

2. For medical BENEFITS not submitted by the HEALTH CARE PROVIDER to WPS, you must use a medical claim form. You may obtain this form from WPS. Save your itemized bills or statements for all covered medical SERVICES. All receipts and bills must be fully itemized. Cash register receipts, canceled checks and balance due statements are not acceptable. Receipts and bills must be originals.

3. Be sure that all receipts and bills include: the patient's name and identification number; provider's name and address; date(s) of service, diagnosis and diagnostic code and procedure code; the charge for each date of service. Be sure to use a separate claim form for each family member for each CALENDAR YEAR. After subtracting the DEDUCTIBLE and COINSURANCE, WPS will process the balance of the CHARGES.

4. For SERVICES outside of Wisconsin, the HOSPITAL or PHYSICIAN can verify your coverage in out of state emergencies by calling WPS toll free during regular business hours.

5. Payment is made for reasonable CHARGES incurred anywhere in the United States or Canada. WPS will determine reasonable CHARGES for appropriate MEDICAL SERVICES or other items required while you are traveling in other countries. Obtain information on foreign currency exchange rates at the time CHARGES were incurred and an English language itemized billing to facilitate processing of your claim when you return home.

6. MEDICARE eligible PARTICIPANTS should include a copy of MEDICARE'S Explanation of Benefits along with the appropriate claim form and receipts. Claims may also be forwarded directly from MEDICARE to WPS. Please see subsection "MEDICARE Cross-Over" below.

MEDICARE Cross-Over

WPS has an agreement with MEDICARE to cross-over claims for any SERVICES that MEDICARE processed as primary. MEDICARE will automatically forward your Explanation of MEDICARE Benefits (EOMB) to WPS for SERVICES you receive throughout the United States.

Cross-over applies to both MEDICARE Part A and B claims. It is designed to eliminate some of the paperwork involved in filing claims, therefore you will not need to send copies of your EOMB to WPS to receive BENEFITS under the PLAN.

Automatic claim forwarding is automatic for each person covered under MEDICARE. You do not need to complete a form or contact WPS to take advantage of cross-over.

Provider Directory

You can access HEALTH CARE PROVIDERS, HOSPITALS, specialists and more through WPS' interactive and easy-to-use online Provider Directory. It's updated regularly to offer you the most current listing of HEALTH CARE PROVIDERS in your network. Simply follow these instructions to locate the HEALTH CARE PROVIDERS of your choice:

1. Access the WPS website at www.wpsic.com/state;

2. Click the "Find a Doctor" tab found on the top center side of the page, then follow these instructions:

a. Select the network you're interested in, that is the Statewide/National (PPP) network.

b. Select your network on the lower part of the page by clicking under "Find a Doctor", "Locate Providers in Wisconsin or in States Bordering Wisconsin", "Locate Providers for All Other Areas", or under "National Network." For providers outside of Wisconsin, but in adjacent counties, you may select either option.

c. Enter the search criteria to find your doctor. You can search by doctor's name, specialty, or location. Use the look-up buttons for the best search results, then click the "Continue" button.

d. Read the disclaimer, then click "Continue to Search Results" to view your search results.

e. On the Search Results page, you'll find a listing of the providers, contact information, addresses, directions and the networks they are part of. You can either print these pages to have them formatted in a PDF directory by clicking the applicable link near the top of your Search Results page.

f. If your search did not yield the results you were looking for, try another search with broader criteria. For example: if you are looking for a general PHYSICIAN (no specialty), search using the criteria "family practice" or "internal medicine" and enter a city or county. Or, to find a particular HOSPITAL or facility, type the word "HOSPITAL" in the specialty area, then enter a city or county.

If you have questions, prefer a hard copy of your provider directory, or do not have access to a computer, please contact Member Services at (800) 634-6448.

Coordination of Benefits

The insurance industry has developed a standard policy provision called Coordination of Benefits (COB) which applies when there is duplicate coverage. Your HEALTH PLAN contains a coordination of benefits provision. When both husband and wife are working, members of the family are often covered by more than one group medical plan. COB provides that your BENEFITS will be "coordinated" with the benefits to which you or one of your eligible DEPENDENTS may be entitled to receive from another group plan or any governmental program. The purpose of COB is to allow you to receive up to 100% of covered medical expenses from all group plans combined - but no more. Please see exclusion #12. under section "Exclusions".

Understanding Your Explanation of Benefits (EOB)

The Explanation of Benefits (EOB) is a summary of how CHARGES were processed under your health PLAN for each covered family member. To simplify your record keeping, WPS lists only one HEALTH CARE PROVIDER and one patient on each EOB. this will allow you to easily match the EOB with your HOSPITAL, doctor or clinic bill. It's always wise to keep a copy of your EOB for your records. While the EOB is straightforward and easy to read, the first few times you look at it may be somewhat overwhelming. That is why WPS has created the following sample EOB form and corresponding explanation of the most pertinent information.

WPS HEALTH INSURANCE®

Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway - Box 8190 - Madison, WI 53708

EXPLANATION OF BENEFITS
THIS IS NOT A BILL - SAVE FOR YOUR RECORDS
Printed on 08/19/2010 Page 2 of 3

Questions?
Call 800-221-5313 or 608-221-1600
TTY/TTD Call 800-351-9945 or 608-222-1879

A DETAIL INFORMATION
(See Remarks for Definitions)

6 **Claim #:** 923911890
5 **Process Date:** 09/02/09
2 **Member #:** 000000000
4 **Group-Division #:** 123456-00001
1 **Member Name:** SMITH, WILLIAM
3 **Group Name:** ABC SUPPLY COMPANY
7 **Patient Name:** SMITH, JOHN
8 **Patient Account:** 11111111

9 Services Provided By / Date of Service / Servicing Provider	Service Dates 10 From	To	11 Total Billed	12 Provider Discount	13 Amount Not Covered	14 Your Copay	15 Your Deductible	16 Your Coinsurance	17 Paid	18 WPS Paid	19 Other Insurance	20 See Remarks
MID MI REG MED-CLARE												
450-EMERG	08/14/09	08/14/09	20.00	3.06	0.00	16.94	0.00	0.00		0.00		TQ, OV
450-EMERG	08/14/09	08/14/09	40.00	6.12	0.00	33.88	0.00	0.00		0.00		TQ, OV
450-EMERG	08/14/09	08/14/09	422.00	64.57	0.00	49.18	0.00	0.00	100	308.25		TQ, OV
250-DRUGS	08/14/09	08/14/09	3303.63	505.46	0.00	0.00	0.00	279.82	90	2518.35		TQ
Payment To Provider On 09-08-09												
		CLAIM TOTALS:	**$3785.63**	**$579.21**	**$0.00**	**$100.00**	**$0.00**	**$279.82**		**$2826.60**	**$0.00**	

B

	Total Billed	Provider Discount	Amount Not Covered	Your Copay	Your Deductible	Your Coinsurance	WPS Paid	Other Insurance	What You Owe
STATEMENT TOTALS:	$3785.63	$579.21	$0.00	$100.00	$0.00	$279.82	$2826.60	$0.00	$379.82

C REMARKS

Remarks	Code	Explanation
TQ	45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THANK YOU FOR USING A CONFINITY PREFERRED PROVIDER. THIS AMOUNT IS A DISCOUNT USING A SPECIAL CONTRACT RATE FOR THIS SERVICE PROVIDED BY THIS PROVIDER. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT
OV	3	CO-PAYMENT AMOUNT. THIS SERVICE HAS A PER VISIT DEDUCTIBLE OR COPAY WHICH IS THE PATIENT'S RESPONSIBILITY.

D WHAT I NEED TO KNOW FOR MY NEXT CLAIM
(FOR THE PERIOD 1/1/2010 - 12/31/2010)

Benefit	Benefit Amount	Amount Met	Remaining
Individual In-Network Deductible	500.00	0.00	500.00
Individual In-Network Out-of-Pocket	1000.00	381.37	618.63
Individual Out-of-Network Deductible	500.00	0.00	500.00
Individual Out-of-Network Out-of-Pocket	1500.00	381.37	1118.63
Lifetime Maximum Benefit	2,000,000.00	11,330.47	1,988,669.53

Benefit status is current as of the time of printing. These amounts may be subject to outstanding adjustments.

E DID YOU KNOW?

The Member Health Center at www.wpsic.com provides action-oriented tools and information that you can use in the day-to-day management of chronic conditions like asthma and diabetes. Visit the WPS website today to learn more!

A Detail Information

Provides details on each medical service provided.

1. **Member Name:** The person insured by WPS (policyholder).
2. **Member Number:** Number associated with each member, shown on your WPS ID card.
3. **Group Name:** Employer Name (if covered under a group plan) or Individual Plan Name (if covered under an individual plan).
4. **Group-Division Number:** Unique code identifying your health plan in our claims system.
5. **Process Date:** The date WPS processed this claim.
6. **Claim Number:** Unique code identifying the claim submitted.
7. **Patient Name:** Lists the person(s) who received health care services.
8. **Patient Account:** Unique health care provider code identifying the patient treated.
9. **Services Provided By:** The provider that performed the procedure, plus the code and general category of the procedure performed.
10. **Service Dates:** The start and end date during which the listed procedure was performed.
11. **Total Billed:** The total cost of the procedure, as billed by the provider.
12. **Provider Discount:** The discount WPS negotiated with your provider, which will be subtracted from the total cost. Usually based on contractual agreements between WPS and providers in your WPS network.
13. **Amount Not Covered:** The portion of the total cost not covered under your health plan. This portion is your responsibility. See Remarks codes in the last column and the Remarks box for explanation.
14. **Your Copay:** The portion of the total cost you are responsible to pay before any deductible or coinsurance is applied for certain covered services (e.g., office visits).
15. **Your Deductible:** The portion of total cost applied to your deductible. (Your deductible is the amount of covered charges you must pay each calendar year before WPS pays benefits).
16. **Your Coinsurance:** The balance of total cost after subtracting provider discount, ineligible amount, copay, and deductible.
17. **Paid at %:** The percentage of the coinsurance amount paid by WPS.
18. **WPS Paid:** The portion of the coinsurance WPS paid.
19. **Other Insurance:** The portion of the coinsurance paid by another insurance plan (e.g., auto insurance).
20. **See Remarks:** The procedure performed may have triggered additional comments that do not fit in the chart. Match the Remarks code to those in the Remarks box under the chart to view the specific comment.

B Statement Totals

A summary of total charges billed by health care providers, negotiated provider discounts, WPS' financial responsibility and yours. What you owe is the portion of coinsurance you are responsible to pay. Includes copay, deductible, coinsurance, and any amount not covered. Paid directly to your provider, who will send you a bill.

C Remarks

Includes explanations of any Remarks codes listed in the See Remarks column.

D What I Need To Know For My Next Claim

Lists your plan's deductible, out-of-pocket maximum, and individual lifetime benefit; shows the amount of each you've met year-to-date; and the amount remaining.

E Did You Know?

Tips and announcements to help you get the most out of your benefit plan.

Please consult your Member Guide for more detailed definitions of these terms. If you have any questions, please contact Member Services at the number listed on the back of your WPS ID card.

PHARMACY BENEFIT MANAGER (PBM)

SCHEDULE OF BENEFITS

The following description of the pharmacy benefit program is an excerpt from parts of Uniform Benefits that now apply to your prescription drug coverage. This is printed here for your convenience. A complete description of benefits, exclusions and limitations can be found in your "It's Your Choice: Reference Guide" book in the Uniform Benefits section in I Schedule of Benefits and III Benefits and Services D. Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM). Exclusions and limitations are found under IV #11. All benefits are paid according to the terms of Uniform Benefits.

All benefits are paid according to the terms of the Master Contract between the PBM and Group Insurance Board. The Schedule of Benefits describes certain essential dollar limits of your coverage and certain rules, if any, you must follow to obtain covered services.

The Group Insurance Board has decided to utilize a PBM to provide prescription drug benefits. The PBM will be responsible for the prescription drug benefits as provided for under the pharmacy benefit terms and conditions of the Uniform Benefits. The prescription drug benefits are dependent on your being covered under the State of Wisconsin group health program.

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

1. Prescription Drugs and Insulin:

- **a.** Level 1 - copayment for formulary prescription drugs - $5.00. Level 1 consists of formulary generic and certain low cost brand name drugs.
- **b.** Level 2 - copayment for formulary prescription drugs - $15.00. Level 2 consists of formulary brand name and certain higher cost generic drugs.
- **c.** Level 3 - copayment for non-formulary prescription drugs - $35.00.

2. Annual Out-of-Pocket Maximum (The Amount You Pay for Your Level 1 and Level 2 Prescription Drugs and Insulin):

$1,000.00 per individual $2,000.00 per family for all participants

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.

3. Disposable Diabetic Supplies and Glucometers:

Coinsurance - Payable at 80%, which will be applied to the prescription drug annual out-of-pocket maximum.

4. Smoking Cessation:

Limited to one consecutive three-month course of pharmacotherapy covered per calendar year.

The PLAN, not the Pharmacy Benefit Manager, will be responsible for covering prescription drugs required to be administered during home care, office setting, confinement, emergency room visit or urgent care setting if otherwise covered under the CONTRACT. 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 the prescription drug benefits of the CONTRACT.