It's Your Choice: Reference Guide

Group Health Insurance Information

Bayfield Apple Festival

State of Wisconsin Employees
Retired State of Wisconsin Employees (Annuitants)
Members with Continuation Coverage (Continuants)
UW Graduate Assistants

Turn The Page To Find The Information Most Important To You

ET-2107r-13 (10/12)

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

ANNUITANTS, be sure to read...

- Medicare Information, including Parts A, B and D, and Eligibility on Pages 48 through 54
- Pharmacy Benefit Manager Information on Pages 54 through 55
- Uniform Benefits Schedule of Benefits on Pages 68 through 73

ACTIVE EMPLOYEES and GRADUATE ASSISTANTS, be sure to read...

- Dependent Information on Pages 33 through 42
- Pharmacy Benefit Manager Information on Pages 54 through 55
- Uniform Benefits Schedule of Benefits on Pages 68 through 73

NEW RESOURCE with information on commonly requested benefits and services...

- Uniform Benefits Quick Reference Guide on Pages 118 through 119

Photos courtesy of the Wisconsin Department of Tourism, Bayfield Chamber of Commerce and Visitor Bureau, Prairie Dog Blues Festival, Horicon Chamber of Commerce, Jefferson Gemuetlichkeit Days Festival and the Sturgeon Bay Visitors Center.

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

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

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State and Federal Notifications

Notice of Privacy Practices

COBRA: Continuation of Coverage for Group Health Insurance

HIPAA: Privacy, Standards and Security

HIPAA: Special Enrollment Opportunities

Independent Review

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

National Medical Support Notice

PPACA: Patient Protection Disclosure

Women's Health Cancer Rights Act of 1998

Early Retirees Reinsurance Program

Sun Prairie Sweet Corn Festival

Notice of Privacy Practices for the

STANDARD PLAN, STATE MAINTENANCE PLAN, MEDICARE PLUS

(Administered by WPS Health Insurance)

PRESCRIPTION DRUG BENEFIT PLAN

(Administered by Navitus Health Solutions)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US. PLEASE REVIEW IT CAREFULLY.

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

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

PLEASE REVIEW THIS DOCUMENTATION CAREFULLY

OUR RESPONSIBILITIES

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

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

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

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

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

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

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

Payment: We may use or disclose your protected health information for the payment of covered services that you receive under your benefit plan, or to otherwise manage your account or benefits. Payment includes activities by ETF or organizations hired by ETF to obtain premiums, to make coverage determinations and to provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management and billing. We may also use and disclose your protected health information to determine premium costs, underwriting, rates and cost-sharing amounts. For example, we may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate the payment of your benefits.

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

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

- Reviews and auditing, including compliance reviews, ombudsperson services, legal services and audit services;
- Business management and general administrative activities, including customer service; and
- Fraud and abuse detection, and compliance programs.

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

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

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

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

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

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

YOUR HEALTH INFORMATION RIGHTS

You have rights under federal privacy laws relating to your protected health information. If you wish to exercise any of the following rights, please submit your

request in writing to the ETF Privacy Officer using the contact information provided at the end of this notice. We are not required to agree to every request. We will notify you if we approve your request or explain the reason for our decision if we deny your request. We may charge you a fee to cover the costs of processing your request. If so, we will inform you of the fee before proceeding.

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

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

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

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

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

Complaints: If you feel that your privacy rights have been violated, you may file a complaint by contacting ETF's Privacy Officer using the information provided on the next page. Federal law prohibits any retaliation against you for filing a complaint. You may also file a complaint with the federal Office for Civil Rights.

Privacy Rights Contact Information

Department of Employee Trust Funds (ETF)
Phone toll free: 1-877-533-5020
Local: 1-608-266-3285
Fax: 1-608-267-0633

Mailing Address for Written Correspondence:
ETF c/o Privacy Officer
P.O. Box 7931
Madison, WI 53707-7931

Secure e-mail correspondence available by accessing our Internet site at etf.wi.gov/contact.htm, click on the "EMAIL US" link.

Office for Civil Rights
Chicago Contact Information:
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone: 1-312-886-2359
Fax: 1-312-886-1807
TDD: 1-312-353-5693

Effective date: October 9, 2006

COBRA: CONTINUATION OF COVERAGE PROVISIONS FOR THE GROUP HEALTH INSURANCE PROGRAM

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

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

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

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

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

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

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

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

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

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

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

The employee or a family member has the responsibility to inform the employer of a divorce or a child losing dependent status. Under the law, ETF must receive your application to continue coverage, postmarked within 60 days from the termination of your current coverage or within 60 days of the date you were

notified by your employer of the right to choose continuation coverage, whichever is later. If ETF is not notified within 60 days of the date of these two events, the right to continuation coverage is lost.

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

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

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

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

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

HIPAA: PRIVACY, ELECTRONIC TRANSACTIONS STANDARDS AND SECURITY

HIPAA administrative simplification rules are intended to simplify and streamline the health care claims and payment process through the implementation of national standards. The rules also require that your health information be protected from unauthorized use or disclosure. The three components of the rules are privacy, electronic data transaction standards and security. The privacy rule came into effect on April 14, 2003, and establishes limits on how your health information can be used and disclosed. The transaction standards rule, which sets out uniform methods for conducting electronic transactions, was effective on October 16, 2003. The security rule requires safeguards for health information maintained in electronic form, and was effective on April 21, 2005.

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

HIPPA: SPECIAL ENROLLMENT OPPORTUNITIES

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

INDEPENDENT REVIEW

In addition to the internal grievance process that all health plans are required to provide, federal law and Wis. Adm. Code § INS. 18.11 requires all health plans to have an independent review procedure for review of certain decisions. These include denial of, or refusal to pay for, treatment that the insurer considers to be experimental/investigational, not medically necessary, inappropriate such as for health care setting or level of care, due to a preexisting condition exclusion denial or rescission of coverage.

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

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

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

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

If you or your dependents are NOT currently enrolled in BadgerCare Plus and you think you or any of your dependents might be eligible for this program, you can contact your local county or tribal human services or social services office. You may also check Wisconsin's ACCESS Internet site to find out if you may qualify and to apply for the program online. The link to ACCESS is **https://access.wisconsin.gov/**, or you may call 1-800-362-3002 to request that an application form be mailed to you. Please note that if the state pays at least 80% of the cost of the premiums for employees and their dependents, they may not qualify for BadgerCare Plus. Beginning July 1, 2012, if the premiums for employee-only coverage are not more than 9.5% of your household income, you and/or your spouse may not qualify for BadgerCare Plus. If you reside outside Wisconsin, you can dial 1-877-KIDS NOW or visit their website at **www.insurekidsnow.gov** to find out how to apply in your state.

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

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.gov
1-877-267-2323, ext. 61565

Egg Harbor Pumpkin Festival

NATIONAL MEDICAL SUPPORT NOTICE

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

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

Patient Protection and Affordable Care Act (PPACA)

PPACA: PATIENT PROTECTION DISCLOSURE

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

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

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

WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998

This Act requires annual notification of coverage under this program for the following treatments in connection with a mastectomy: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas. For more information, contact the health plan. Plan contact information is available on the inside back cover of the *It's Your Choice: Decision Guide*.

EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of,

Milwaukee Lakefront Festival of Arts

or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

You are responsible for providing a copy of this notice to your family members who are participants in this plan.

PATIENT RIGHTS AND RESPONSIBILITIES

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

Jefferson Gemuetlichkeit Days

YOU HAVE THE FOLLOWING RIGHTS:

• Considerate, respectful care from all members of the health care system.

• Non-discrimination consistent with state and federal law.

• To change plans annually.

• To a description of benefits presented in an understandable manner. Uniform Benefits are described in this booklet. Outlines of coverage for the Standard plans are found in the *It's Your Choice: Decision Guide*. If you select one of the Standard plans, you will receive a certificate of coverage that describes your benefits. Your plan may also provide additional information regarding pre-certification requirements, etc.

• To select a primary care physician and to have access to appropriate specialty care. You have the right to a referral to a non-plan specialist for covered services if there is not a plan specialist who is reasonably available to treat your condition.

• A woman has the right to have access to an OB/GYN provider.

• A woman has the right to a minimum hospital stay of 48 hours following a normal delivery of a child or 96 hours following a cesarean delivery. The physician, in consultation with the mother, may discharge the mother and baby prior to the expiration of the minimum stay.

• To have continuous and appropriate access to a provider for the remainder of that calendar year if the provider leaves the plan (other than for misconduct, retirement or a move from the service area). A woman in her second or third trimester of pregnancy has access to that provider until the completion of postpartum care. This right only applies to providers that are listed in the available plan's provider directory available during the It's Your Choice Open Enrollment period.

• To have access to emergency care without prior-authorization from the plan. If it is not reasonably possible to use a plan hospital or facility, you have the right to obtain treatment at the nearest facility and have those charges covered by the plan as if you did use the plan hospital or facility (however, be aware of your responsibilities when emergency care is received).

• To participate with your provider in treatment decisions.

• To confidentiality of medical information and your Social Security number.

• To execute a living will or durable power of attorney for health care if you are age 18 or older. These documents tell others what your wishes are in the event that you are physically or mentally unable to make medical decisions or choices yourself.

• To appeal any referral or claim denial through the plan's grievance process. This review will be conducted in a timely manner. Grievances related to care which is urgently needed must be reviewed by the plan within four working days. If you have exhausted all levels of appeal available through the plan, you may submit a complaint to ETF, in care of the Office of Legal Services. You will need to submit an Employee Trust Funds Complaint form (ET-2405). You also have the right to request a departmental determination if you

believe that a plan did not comply with its contractual obligations.

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

YOU HAVE THE FOLLOWING RESPONSIBILITIES

• During the It's Your Choice Open Enrollment period, to review the It's Your Choice: Decision Guide and information provided by your plan. This information is important to determine if your plan and/or your providers will continue to be available and whether your current plan continues to best meet your needs for the following calendar year.

• To submit your application for coverage prior to the end of the enrollment period, if you select a different plan during the It's Your Choice Open Enrollment period.

• To select a primary care physician who will oversee your total health care and to make a reasonable effort to establish a satisfactory patient/physician relationship.

• To become involved in your treatment options and/or treatment plan.

• To become knowledgeable about your health insurance coverage and your health plan, including covered benefits, limitations and exclusions, and the process to appeal coverage decisions. If you are covered under an HMO or preferred provider plan, to also become knowledgeable about the plan's rules regarding use of network providers, prior authorizations and referrals.

• To authorize the release of relevant personal or medical information necessary to determine appropriate medical care, to process a claim or to resolve a dispute.

• To notify your plan by the next business day, or as soon as reasonably possible, if you receive emergency or urgent care from a non-plan provider.

• To promptly report any family status changes to your payroll representative (or ETF if you are an annuitant or continuant). These changes include marriage, divorce, creation or termination of a domestic partnership, death, a birth or adoption, or a dependent child losing eligibility. You should also report address or name changes, a change in your primary care provider and Medicare eligibility.

• To respond to the plan's annual questionnaire on eligibility for any adult dependent who may be disabled. Coverage for dependents could be lost if the questionnaire is not returned to the plan or the review is not completed..

• To notify your plan if you obtain or lose other health insurance – **including Medicare**.

• To submit claims to the plan in a timely manner, if applicable.

• To use the plan's internal grievance process to address concerns that may arise.

Frequently Asked Questions

Included is detailed information regarding enrollment and plan change opportunities beyond the annual It's Your Choice Open Enrollment period, dependent eligibility, benefits and services, Medicare, and termination of coverage.

Frequently Asked Questions about the annual It's Your Choice Open Enrollment period, changing from single to family coverage, submitting your changes electronically (using the myETF Benefits Internet site at **http://myETF.wi.gov/ONM.html** unless otherwise instructed by your employer), selecting a health plan and new topics for the year appear in the *It's Your Choice: Decision Guide*.

Prairie du Chien Prairie Dog Blues Festival

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For information regarding the annual open enrollment period and what's new, see the *Frequently Asked Question* section in the *It's Your Choice: Decision Guide*. Questions in this section apply to everyone except when described as State, Grad and/or Annuitants only. Refer to Question 1 for further details.

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GENERAL INFORMATION

1. Who is eligible for State of Wisconsin group health insurance?

Information about the State of Wisconsin Group Health Insurance Program in this guide applies to the following individuals:

The Following Will Be Considered Active Employees:

Eligible State Employees (Hereafter called "State" in this booklet section.)

- Active state and university employees participating in the Wisconsin Retirement System (WRS).
- Elected state officials.
- Members or employees of the legislature.
- Certain visiting faculty members in the University of Wisconsin System.
- Blind employees of the Workshop for the Blind (Wiscraft) with at least 1,000 hours of services.
- Employees on leave of absence who continue their insurance.

Eligible Graduate Assistants (Hereafter called "Grad" in this booklet section.)

- Graduate Student Assistants (Research Assistants, Fellows, Advanced Opportunity Fellows, Scholars, Trainees, Teaching Assistants and Project/Program Assistants) holding a combined one-third (33%) or greater appointment of at least one semester for academic year (nine month) appointments or six months for annual (12 month) appointments.
- Employees-in-Training (Research Associates, Post-Doctoral Fellows, Post-Doctoral Trainees, Postgraduate Trainees 1 through 7, Interns (non-physician), Research Interns, Graduate Interns/Trainees holding a combined one-third time (33%) or greater appointment of at least one semester for academic year (nine month) appointments or six months for annual (12 month) appointments.
- Short-Term Academic Staff who are employed in positions not covered under the WRS and who are holding a fixed-term terminal, acting/provisional or interim (non UW-Madison) appointment of 28% or more with an expected duration of at least one semester but less than one academic year if on an academic year (nine month) appointment or have an appointment of 21% or more with an expected duration of at least six months but less than 12 months if on an annual (12 month) appointment.
- "Visiting" Appointees (e.g., Visiting Professors, Visiting Scientists, Visiting Lecturers) may be eligible for the health insurance benefits described in this guide. If you hold a "visiting" appointment, contact your benefits/payroll/personnel office for more information.

The Following Will Be Considered Former Employees:

Eligible State Annuitants and Continuants (Hereafter called "Annuitants" in this booklet section.)

- Retired state employees who are enrolled at the time of retirement and whose retirement annuity from the WRS begins within 30 days after employment ends.

- Insured employees who terminate employment and have 20 years of WRS creditable service are eligible to continue the State of Wisconsin Group Health Insurance Program even if the annuity is deferred if a timely application is submitted.
- State employees receiving a WRS disability benefit.
- The following former state employees who are not covered under the State of Wisconsin Group Health Insurance Program may apply for coverage (See Question 7: *What if I didn't have health insurance coverage at retirement or my coverage later lapsed?)*:
  1. Retired state employees receiving a WRS retirement annuity or a lump sum benefit under Wis. Stat. § 40.25(1); or
  2. Terminated state employees with 20 years of WRS creditable service who remain as inactive WRS participants and are not eligible for an immediate annuity.

INSURANCE COMPLAINT PROCESS

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

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

Depending on the nature of your complaint, you may be given rights to request an independent review through an outside organization approved by the Office of the Commissioner of Insurance. This option becomes available when a plan has denied services as either not medically necessary or experimental, or due to a preexisting condition exclusion denial or rescission of coverage. **Note:** If you choose to have an independent review organization (IRO) review the plan's decision, that decision is binding on both you and your plan except for any decision regarding a preexisting condition exclusion denial or the rescission of coverage. Apart from these two exceptions, you have no further rights to a review through ETF once the IRO decision is rendered.

3. How can the ETF help me if I disagree with my health plan's grievance decision?

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

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

ENROLLING FOR COVERAGE

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

- Determine which plans have providers in your area.
- Contact the health plans directly for information regarding available physicians, medical facilities and services.
- Review the health plan Rates, Report Card Information and the Plan Descriptions located in the *It's Your Choice: Decision Guide*.
- File an application electronically using the myETF Benefits link online at http://myETF.wi.gov/ONM.html unless otherwise instructed by your employer, or by submitting a paper *Health Insurance Application/ Change Form* (ET-2301). Active employees should file with their benefits/payroll/personnel office. Annuitants and continuants should file with ETF.

EMPLOYEE ENROLLMENT

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

(State and Grad) If eligible, you may enroll for single or family coverage in any of the available health plans without restriction or waiting periods for preexisting medical conditions, provided you file an electronic or paper health application with your benefits/ payroll/personnel office within the required enrollment period stated below:

1. Within 30 days of your date of hire or first eligible appointment. Coverage will be effective the first day of the month on or following receipt of the application by your employer either electronically or via paper. You will have to pay the entire premium prior to becoming eligible for the employer share of the contribution. Check with your payroll person to see when your employer contribution begins.

2. Prior to becoming eligible for employer contributions toward premium as defined in Wis. Stat. § 40.05 (4) (a) (2), with coverage to be effective when you become eligible for employer contributions. Contact your payroll/benefits/ personnel office for more information.

3. You may also enroll during the annual It's Your Choice Open Enrollment period for coverage to be effective January 1 of the following year. OR

4. **(Grad only)** If this is not your first eligible appointment, you may still be eligible for the "initial" 30-day enrollment period if you had a 30-day employment break between appointments.

There are no interim effective dates except as required by law. If you do not submit a completed application within 30 days of your date of hire, your coverage cannot be effective before the month you become eligible for the employer contribution toward health insurance premiums. However, you may enroll for single coverage within 30 days of your date of hire and change to family coverage if your electronic or paper application is received prior to the date the employer contributions begin.

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

You cannot assume that the month when your first payroll deduction occurs is the month when your coverage begins. For further information on deductions and coverage effective dates, contact your benefits/payroll/personnel office.

(State only) Important information for Limited Term Employees (LTE) and Employees not eligible for full-time contributions:

- For LTEs who are enrolling for coverage, employer contribution would become available upon completion of **six months** under the WRS.
- The initial enrollment opportunity for most employees begins with their participation under the WRS. However, if you are in a WRS-covered LTE position or an employee who is eligible but appointed to work less than 1,044 hours per year, you have another enrollment period if:

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

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

ANNUITANT ENROLLMENT

Important Note: If you are eligible or will become eligible for Medicare, you will also want to refer to the Medicare Information in the Benefits and Services Section of this guide.

6. When can I enroll in the health insurance program as an annuitant?

When you retire, your health insurance plan will automatically continue if

your retirement annuity from the WRS begins within 30 days after your employment termination date. If you terminate employment after 20 years of creditable service but are not eligible for an immediate annuity, your completed *Health Insurance Application/Change Form (ET-2301)* with a *Continuation-Conversion Notice (ET-2311)* must be received by ETF within 90 days of your termination of employment to continue coverage. You may switch coverage to any other available plan during the It's Your Choice Open Enrollment period (see also Question 59).

7. What if I didn't have health insurance coverage at retirement or my coverage later lapsed?

For WRS Annuitants only, (Note: a 40.65 disability benefit is not a WRS disability annuity under the law.)

An enrollment opportunity is available to former state employees receiving a WRS retirement annuity or those who received a lump sum WRS retirement benefit. This option is not available to survivors or dependents.

To enroll or re-enroll:

- You must submit a *Health Insurance Application/Change Form (ET-2301)* to ETF during the annual It's Your Choice Open Enrollment period.
- You would not be eligible to use any sick leave credits to pay premiums if you enroll under this provision. There are separate enrollment opportunities for those individuals who have escrowed their sick leave. *(See Other Enrollment Opportunities below or contact ETF for details on this process.)*

8. Can I delay or initiate use of sick leave credits after I retire?

Yes. For WRS annuitants, 40.65 disability or LTDI recipients, or their surviving insured dependents, if you are eligible to use your sick leave credits, you may elect to delay use (escrow) or initiate use (unescrow) of sick leave credits annually. In order to escrow, you must certify that you have health coverage comparable to the State of Wisconsin's Standard Plan. You may escrow only once during a calendar year, and your credits will be in escrow the first of the month following receipt of the *Sick Leave Escrow Application (ET-4305)*. You may unescrow during It's Your Choice Open Enrollment period for coverage effective January 1 of the following year or the first of the month in the following year that you select. In addition, if you lose eligibility for your comparable coverage (not voluntary cancellation) or the contribution for it (if it is an employer sponsored plan), you may unescrow (re-enroll) by filing an application within **30 days** of the loss. *(See the Sick Leave Conversion Credit Program brochure (ET-4132) for more information or contact ETF at 1-877-533-5020.)*

(State only) If you are an employee who deferred coverage and who wants to preserve your sick leave credits for later use, you may enroll for coverage in the Standard Plan immediately prior to retirement.

OTHER ENROLLMENT OPPORTUNITIES

9. Are there other enrollment opportunities available to me after my initial one expires?

You may be able to get health

insurance coverage if you are otherwise eligible under specific circumstances as described below:

- If you are an active employee, and you and/or your dependent(s) are not insured under the State of Wisconsin Group Health Insurance Program because of being insured under a group health insurance plan elsewhere, you may take advantage of a special **30-day** enrollment period to become insured in the State of Wisconsin Group Health Insurance Program without waiting periods for preexisting conditions as described below. These also apply to annuitants, if your annuity began (or you received a lump sum retirement benefit) within 30 days after your employment termination date AND you have escrowed your sick leave account:

1. Your eligibility for that other coverage is lost or the employer's premium contribution for the other plan ends,

OR

2. You and/or your dependents lose medical coverage:

   - Under medical assistance (Medicaid); or
   - Upon return from active military service with the armed forces. Employees must return to employment within **180 days** of release from active duty. You are entitled to enroll regardless of the coverage in effect. Coverage is effective on the date of your re-employment; or
   - As a citizen of a country with national health care coverage comparable to the Standard Plan.

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

- If you are currently enrolled in the State of Wisconsin Group Health Insurance Program with single coverage, because your dependents are insured under a group health insurance plan elsewhere, and eligibility for that coverage is lost or the employer's premium contribution for the other plan ends, you may take advantage of a special **30-day** enrollment period to change from single to family coverage without waiting periods for preexisting conditions.

- If you are currently enrolled in the State of Wisconsin Group Health Insurance Program with family coverage, annually you may request to provide coverage for your eligible adult child who is not currently insured. You do this during the It's Your Choice Open Enrollment period. Coverage for your child will be effective the following January 1.

- **(State and Grad only)** If you are not insured under the State of Wisconsin Group Health Insurance Program and have a new dependent as a result of marriage, domestic partnership,

birth, adoption or placement for adoption, you may enroll if coverage is elected within 30 days of marriage or the effective date of the domestic partnership, or 60 days of the other events. Coverage is effective on the date of marriage, birth, adoption or placement for adoption. Domestic partnership coverage is effective the date ETF receives the completed *Affidavit of Domestic Partnership (ET-2371)*.

- **(State and Grad only)** If you and/or your dependents lose medical coverage under the Children's Health Insurance Program (CHIP) or become eligible to participate in a premium assistance program, you will have an opportunity to enroll in the State of Wisconsin Group Health Insurance Program without waiting periods for preexisting conditions by filing an application either electronically or via paper within 60 days of the loss of eligibility or the date you become eligible for premium assistance and by providing evidence satisfactory to ETF.
- **(Grad only)** If you were eligible for graduate assistant benefits but elected not to enroll in this program upon initial eligibility, you will have a second enrollment opportunity if you later become eligible for a WRS-eligible position even if there is no break in service of 30 days or more.
- **(State and Grad only)** If you do not enroll during a designated enrollment period, you may enroll for health insurance coverage if you are otherwise eligible during the annual It's Your Choice Open Enrollment period.

Note: (Annuitants only) Former state employees who receive a retirement annuity (or have received a lump sum retirement benefit), who would like to enroll or re-enroll in the State of Wisconsin Group Health Insurance Program in most cases will have to do this during the It's Your Choice Open Enrollment period in the fall for January 1, coverage.

CHANGES IN EMPLOYMENT STATUS

ACTIVE EMPLOYEES

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

Temporary Layoff

(State only) State share toward premium will continue for the first three months after your leave begins. You can elect coverage for **36 months** (or beyond 36 months if you are using sick leave to pay premium). *Arrangements for premium payment must be made with your benefits/payroll/personnel office prior to the time your leave of absence begins.*

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

Accumulated sick leave credits may be used to pay premium for up to 5 years. A written request to use sick leave credit must be submitted to your benefits/payroll/personnel office before the date of layoff.

Permanent Layoff

(State only) State contributions toward premium will be 3 months of state contribution in addition to any premium prepaid prior to the time of layoff. Arrangements for employee share of premium payment must be made with your benefits/payroll/personnel office prior to the date of layoff.

Accumulated sick leave credits may be used to pay premium for up to 5 years. A written request to use sick leave credit must be submitted to your benefits/payroll/personnel office before the date of layoff.

After sick leave credits are exhausted or if you have no sick leave credits and state share of premium is no longer available, COBRA continuation will be offered, which will allow you to purchase, at your own expense, an additional **36 months** of coverage.

If you have 20 years of WRS service at the time of the layoff but were not eligible for an immediate annuity at the time of layoff, any sick leave remaining after paying premium during layoff is available upon retirement. You cannot use your sick leave after 5 years from the layoff date until you retire. If you had 20 years of WRS service and were eligible for an immediate annuity at the time of layoff, you may continue to use it after 5 years or begin using the sick leave at anytime.

Unpaid Leave of Absence

(State and Grad only) State share toward premium will be 3 months of state contribution and any premium prepaid at the time your leave of absence begins. You can elect coverage for **36 months** (or beyond 36 months if the leave is military or union service). Arrangements for premium payment must be made with your benefits/payroll/personnel office prior to the time your leave of absence begins. If coverage is not continued during leave of absence, there are no continuation rights if employment terminates.

Note: If your health coverage lapses in whole or only for your dependents during your leave due to non-payment of premiums, you must submit a new application either electronically or via paper within **30 days** of returning to work to reinstate prospectively the coverage that lapsed. Coverage will be effective the first of the month after the application is received by your payroll office. If an It's Your Choice Open Enrollment period has occurred while you were on leave, you will be offered an It's Your Choice enrollment opportunity upon your return.

A leave of absence is not considered ended until you have terminated employment or have resumed employment for at least 50% of what is considered your normal work time for that employer for **30 consecutive calendar days.**

(State only) Lapsed coverage can also be reinstated for an employee who has been on a leave of absence and who is entitled to, and applies for, an immediate annuity. Coverage shall be effective the first day of the calendar month which occurs on or after the date the annuity application

is approved by ETF, provided an application for health insurance has been received by that date.

Military Leave of Absence

(State only) Under Wisconsin state law § 40.05 (4g), Wis. Stat., health insurance coverage may be continued under our program with employer contribution, as long as you are on active duty, your employee premium contribution continues to be paid and you elect coverage within **60 days** of military activation. For more information on this option and the steps you need to take, contact your benefits/payroll/personnel office.

Transfer

(State only) If you transfer from one employing state department to another, you are required to file a new enrollment application either electronically or via paper within **30 days** of the date you transfer to maintain continuous coverage. If an application is not filed within **30 days**, coverage may be reinstated retroactively by submitting an application and paying back premiums. However, an employee in active pay status whose employee portion of premiums has not been deducted from salary by the employer for a period of **12 months**, shall be deemed to have waived coverage. Waived coverage cannot be reinstated retroactively.

You may not select a new plan when you submit your insurance application due to a transfer, unless it coincides with one of the other designated enrollment opportunities.

(Grad only) If you transfer from one employing state department to another, contact your benefits/payroll/personnel office for information on how to maintain continuous coverage.

Termination of Employment

(State and Grad only) Coverage will end at the end of the month in which the employee terminates employment. (See *CONTINUATION OF HEALTH COVERAGE*.)

Appealing a Discharge

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

Retirement

(State only) If you are covered under our health insurance when you retire, the health benefit plan will automatically continue if your retirement annuity from the WRS begins within **30 days** after employment ends. If you are eligible for Medicare, effective dates must be provided before coverage continues. If you do not want your

plan to continue because you are covered under a comparable non-state plan at the time of retirement, you may escrow your sick leave credits to pay health premiums for use later. Contact ETF for further information.

You may be eligible for supplemental sick leave credits if you have at least 15 full years of adjusted continuous service with the state of Wisconsin at the time of retirement. (Continuous service means the number of full years the employee has worked for the state without a break in service. Local service does not apply.) Your employer will determine whether you are eligible for supplemental sick leave credits and submit the certification to ETF. If you have questions regarding your eligibility for supplemental sick leave credits, contact your payroll office.

Medicare Part D

Medicare enrolled retirees will be enrolled in the ***Navitus Medicare Rx (PDP), Underwritten By Sterling Life Insurance Company***. This is Medicare Part D coverage through an Employer Group Waiver Plan (EGWP) administered by Navitus™ Health Solutions, the State group health insurance program's pharmacy benefit manager. This replaces the current creditable coverage provided by Navitus. Wrap coverage is also included to ensure your prescription drugs are covered when you reach the Medicare Part D coverage gap, commonly referred to as the "donut hole." Please see the "MEDICARE INFORMATION" section in the Frequently Asked Questions for additional information. Also see the Navitus plan description pages in the It's Your Choice: Decision Guide for more detailed information.

RE-EMPLOYED ANNUITANTS

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

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

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

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

As a state annuitant, if you were paying for your health insurance

from your converted sick leave credit account, your account will be inactivated if you return to work for a state government employer. Your sick leave credit account will be activated again when you re-retire. Any sick leave credit you accumulate during re-employment with a state government employer will be added to the balance in your account when you re-retire. If your re-employment is with a local government employer, and you have comparable health insurance coverage, you may escrow your sick leave account balance. Contact ETF for a *Sick Leave Escrow Application (ET-4305)*. Your sick leave credit account balance will be available to you when you re-retire.

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

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

13. What if I'm a disability annuitant who returns to work?

(Annuitants only) If you are a disability annuitant under § 40.63(1) who is under normal retirement age and return to any employment, you are subject to a flat rate earnings limit. If you exceed your earnings limit, your disability annuity is **suspended**, but you will remain eligible for health insurance as an annuitant.

If you are receiving a disability annuity, you may not actively participate in the WRS until it is determined that you are no longer eligible for a disability annuity because of medical certification. If your disability annuity is **terminated**, and you are employed by a WRS participating employer, you will become eligible for the health insurance offered by your employer.

- If you return to state employment, you must file a new health application either electronically or via paper within **30 days** after the date you resume active status under WRS.
- If you return to local public employment, you lose eligibility to remain in the State of Wisconsin Group Health Insurance Program. You may enroll in your public employer's health program (if one is offered), or you may elect continuation coverage of the State of Wisconsin Health Insurance Program for up to **36 months** by applying within **60 days** of being notified by ETF of your right to continue.

IMPORTANT CAUTION: Continuation coverage will end after **36 months**. It does **NOT** make you eligible to re-enroll in the state plan when you terminate. You will only be eligible for the health insurance your employer offers its retirees, subject to its rules and requirements.

DEPENDENT INFORMATION

Single coverage covers only you. Family coverage covers those described below. All eligible, listed dependents are covered under a family contract. A subscriber cannot choose to exclude any other eligible dependent from family coverage except as described in *Question 18 When does health coverage terminate for my dependents?*.

DEPENDENT ELIGIBILITY

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

- Your spouse.
- Your domestic partner if elected.
- Your children who include:
  1. Your natural children.
  2. Stepchildren or children of your domestic partner insured on the policy.
  3. Adopted children and pre-adoption placements. Coverage will be effective on the date that a court makes a final order granting adoption by the subscriber or on the date the child is placed in the custody of the subscriber, whichever occurs first. These dates are defined by Wis. Stat. § 632.896. If the adoption of a child is not finalized, the insurer may terminate coverage of the child when the adoptive placement ends.
  4. Legal wards that become your permanent ward before age 19. Coverage will be effective on the date that a court awards permanent guardianship to you (the subscriber or your spouse or Domestic Partner).

Note: Children may be covered until the end of the month in which they turn 26. His/her spouse and dependents are not eligible. Upon losing eligibility, they may be eligible for COBRA continuation. *(See Question 60. Who is eligible for continuation?)*

Coverage may continue beyond that when children:

1. Have a disability of long standing duration, are unmarried dependent on you or the other parent for at least 50% of support and maintenance, and are incapable of self-support; OR
2. Are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education. **Note:** The adult child must apply to an institution of higher education as a full-time student within 12 months from the date the adult child fulfilled his or her active duty obligation

- Your grandchildren born to your insured dependent children may be covered until the end of the month in which your insured dependent (your grandchild's parent) turns age 18. Your child's eligibility as a dependent is unaffected by the birth of the grandchild.

IMPORTANT NOTE: There are state and/or federal tax consequences to you when you provide coverage for

dependents that do not meet the support test for federal income tax purposes. An examples is a domestic partner who is not dependent on you for at least 50% of their support and maintenance.

15. What are my coverage options if my spouse/domestic partner is also a state or participating Wisconsin Public Employer (WPE) employee or state annuitant?

You have the following options:

- If your spouse/domestic partner is also an eligible state or participating WPE employee or annuitant, you may each elect single coverage with your current plan(s) if you have no other eligible dependents; or one of you may select family coverage that will cover all of your eligible tax dependents.
- If both spouses or domestic partners are each enrolled for single coverage and premiums are being deducted on a pre-tax basis, family coverage may only be elected effective at the beginning of the calendar year or when the employees have gained a dependent that necessitates family coverage.
- If premiums are being deducted on a post-tax basis, one of the single contracts may be changed to a family plan at anytime without restriction and the other single contract will be cancelled. Family coverage will be effective on the beginning of the month following receipt of an electronic or paper application, or a later date specified on the application.
- If premium for family coverage is being deducted on a pre-tax basis, coverage may only be changed to single coverage effective at the beginning of the calendar year or when the last dependent becomes ineligible for coverage or becomes eligible for and enrolled in other group coverage.
- If premium is being deducted post-tax, one family policy can be split into two single plans with the same carrier effective on the beginning of the month following receipt of an electronic or paper application, or a later date specified on the application from both spouses or domestic partners.

Note: A subscriber who has family coverage that covers only a domestic partner and/or other non-tax dependents such as a domestic partner's children can change to single coverage at anytime. This is because the non-tax dependent's coverage is taxed as imputed income and not subject to the federal regulations governing pre-tax deductions.

Some things to note:

1. **(State and Annuitants only)** If you and your spouse/domestic partner each have single coverage, no dependents are covered and if one of you should die, that individual's sick leave credits will not be available for use by the surviving dependents. Under a family plan, sick leave credits are preserved for the surviving dependents regardless of who should die first.
2. If you or your spouse/domestic partner have family coverage

and want to change the named subscriber for the family coverage to the other spouse/domestic partner and the premium for coverage is being deducted on a pre-tax basis, coverage may only be changed to the other spouse/domestic partner:

- effective at the beginning of the calendar year;
- when the subscriber carrying the coverage terminates employment or goes on an unpaid leave of absence; or
- the premium contribution increases because of reduced work hours.

For subscribers whose premiums are being deducted on a post-tax basis, coverage can be changed at anytime. Coverage will be effective on the beginning of the month following receipt of an electronic or paper application, or a later date specified on the application.

3. If at the time of marriage, the employees and/or annuitants each have family coverage or one has family coverage and the other has single coverage, **coverage must be changed to one of the options listed above within 30 days of marriage to be effective as of the date of marriage.** Failure to comply with this requirement may result in denial of claims for eligible dependents. **Note**: Change from single to family coverage due to marriage is effective the date of marriage if an electronic or paper application is received by your employer (or for annuitants/continuants by ETF) within **30 days** of the marriage.

4. If at the time a domestic partnership is formed (effective on the date that ETF receives a completed *Affidavit of Domestic Partnership (ET-2371)*), and the employees and/or annuitants each have family coverage, or one has family coverage and the other has single coverage, **coverage must be changed to one of the options listed above within 30 days of the effective date.** Failure to comply with this requirement may result in denial of claims for eligible dependents. **Note**: A copy of the *Affidavit of Domestic Partnership (ET-2371)* and an electronic or paper application must be received by your employer (or for annuitants/continuants by ETF) within **30 days** of the beginning of the domestic partnership. Further information is available on our Internet site, etf.wi.gov.

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

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

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

If your child loses eligibility for

coverage due to age or loss of student status, but you are now indicating that the child meets the disabled dependent definition, eligibility as a disabled dependent must be established before coverage can be continued. If you are providing at least 50% support you must file an electronic or paper application with your employer (ETF for annuitants and continuants) to initiate the disability review process by the health plan. Your dependent will be offered COBRA continuation*.

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

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

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

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

18. When does health coverage terminate for my dependents?

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

- The date eligibility for coverage ends for the subscriber.
- The end of the month in which:
  1. The child turns age 26.
  2. Coverage for the grandchild ends when your child (parent of grandchild) ceases to be an eligible dependent or becomes age 18, whichever occurs first. The grandchild is then eligible for continuation coverage.
  3. Coverage for a spouse and stepchildren under your plan terminates when there is an entry of judgement of divorce.
  4. Coverage for a domestic partner and children of your domestic partner terminates when the ETF *Affidavit of Termination of Domestic Partnership (ET-2372)* is filed.
  5. The child was covered per Wis. Stats. 632.885 (2) (b) and ceases to be a full-time student.

6. The child becomes eligible as an employee of a state agency or an employer who participates in the State of Wisconsin Group Health Insurance Program.
7. You terminate coverage for your adult dependent within 30 days of their eligibility for and enrollment in another group health insurance program. Termination will be effective the first of the month following receipt of an electronic or paper application. You may also terminate coverage for your adult dependent during the annual It's Your Choice enrollment period to be effective January 1 of the following year.

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

FAMILY STATUS CHANGES

19. Which changes need to be reported?

You need to file an electronic or paper application as notification for the following changes to your benefits/payroll/personnel office within 30 days of the change. Annuitants and continuants will need to contact ETF. Additional information may be required. Failure to report changes on time may result in loss of benefits or delay payment of claims.

- Change of name, address, telephone number and Social Security number, etc.
- Obtaining or losing other health insurance coverage
- Addition of a dependent (within 60 days of birth or adoption)
- Loss of dependent's eligibility
- Marriage/domestic partnership
- Divorce/termination of a domestic partnership
- Death (Contact ETF if dependent is your named survivor.)
- **(State and Annuitants only)** Eligibility/Enrollment for Medicare.

20. Who do I notify when a dependent loses eligibility for coverage?

You have the responsibility to inform your benefits/payroll/personnel office (ETF for annuitants and continuants) of any dependents losing eligibility for coverage under the State of Wisconsin Group Health Insurance Program. **Under federal law, if notification is not made within 60 days of the later of (1) the event that caused the loss of coverage, or (2) the end of the period of coverage, the right to continuation coverage is lost.** A voluntary change in coverage from a family plan to a single plan does not create a continuation opportunity.

If your last dependent is losing eligibility, you must file an application to change to single coverage.

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

Marriage

You can change from single to family coverage to include your spouse (and stepchildren if applicable) without restriction provided your electronic or paper application is received within **30 days** after your marriage, with family

coverage being effective on the date of your marriage.

If you were enrolled in family coverage before your marriage, you need to complete an electronic or paper application as soon as possible to report your change in marital status, add your new spouse (and stepchildren) to the coverage and, if applicable, change your name. In most cases, coverage for the newly added dependent(s) will be effective as of the date of marriage. (See *Question 15: What if my spouse/ domestic partner is also a state or university employee or annuitant?*)

Note: You may also change health plans when adding a dependent due to marriage. The subscriber will need to file an application within 30 days of the marriage with coverage effective on the first day of the month on or following receipt of the application.

Domestic Partnership

You can change from single to family coverage to include your eligible domestic partner (and his/her eligible children if applicable) when you submit an *Affidavit of Domestic Partnership (ET-2371)* to ETF. Active employees should submit either an electronic or paper application to your employer, annuitants should submit it to ETF within **30 days** of the date ETF receives a completed *Affidavit of Domestic Partnership (ET-2371)*. Coverage will be effective on the day ETF receives the completed *Affidavit of Domestic Partnership (ET-2371)*. Check etf.wi.gov for tax implications.

If you were enrolled in family coverage before your domestic partnership, you need to complete an ETF *Affidavit of Domestic Partnership (ET-2371)* and an electronic or paper application as soon as possible to report your change in status and add your new domestic partner (and his/ her eligible children) to the coverage. (See *Question 15: What if my spouse/ domestic partner is also a state employee or annuitant?*)

Birth/Adoption/Legal Guardianship/ Dependent Becoming Eligible

If you already have family coverage, you need to submit a timely electronic or paper application to add the new dependent. Coverage is effective from the date of birth, adoption, when legal guardianship is granted, or when a dependent becomes eligible and otherwise satisfies the dependency requirements. Be prepared to submit documentation of guardianship, paternity or other information as requested by your employer.

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

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

Single Mother or Father Establishing Paternity

A subscriber may cover his or her dependent child, effective with the child's birth or adoption, by submitting a timely electronic or paper application changing from single to family coverage.

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

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

Upon Order of a Federal Court Under a National Medical Support Notice

This can occur when a parent has been ordered to insure his/her eligible child(ren) who are not currently covered. You will need to submit an electronic or paper application to your benefits/payroll/personnel office (annuitants and continuants will notify ETF) with coverage becoming effective on either:

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

Divorce

Your ex-spouse (and stepchildren) can remain covered under your family plan only until the end of the month in which the marriage is terminated by divorce or annulment, or to the end of the month in which the *Continuation-Conversion Notice (ET-2311)* is provided to the divorced spouse if family premium continued to be paid, whichever is later. (In Wisconsin, a legal separation is unlike divorce in that it does not affect coverage under the State of Wisconsin Group Health Insurance Program.) The entry of judgment of divorce is usually when the judge signs the divorce papers and the clerk of courts date stamps them. You should notify your payroll office prior to the divorce hearing date and once the entry of judgment of divorce has occurred. You will need to contact the clerk of courts to learn the date of entry of judgment of divorce. If you fail to provide timely notice of divorce, you may be responsible for premiums paid in error which covered your ineligible ex-spouse and stepchildren. Your ex-spouse and stepchildren are then eligible to continue coverage under a separate contract with the group plan for up to **36 additional months.** Conversion coverage would then be available. You can keep your dependent children and adopted stepchildren on your family plan for as long as they are eligible (age, student status, etc.). *(See the CONTINUATION OF HEALTH COVERAGE section for further information.)*

You must file an electronic or paper health application with your employer to change from family to single coverage or to remove ineligible dependents from a family contract.

When both parties in the divorce are state or university employees or annuitants, and each party is eligible for state health insurance in his or her own right and is insured under the state plan at the time of the divorce, each retains the right to continue state health insurance coverage regardless of the divorce.

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

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

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

Note for active employees: Failure to apply in a timely manner will limit enrollment to the annual It's Your Choice Open Enrollment period for January 1, coverage.

Note for annuitants and continuants: Failure to apply in a timely manner will delay the effective date of coverage.

Termination of a Domestic Partnership

Your former domestic partner (and eligible children of a domestic partnership) can remain covered under your family plan only until the end of the month in which ETF receives your *Affidavit of Termination of Domestic Partnership (ET-2372)*. If you fail to provide timely notice of termination of the domestic partnership, you may be responsible for premiums paid in error which covered your former domestic partner and children of a domestic partnership. After termination, your ex-domestic partner and ineligible children of the domestic partnership are then eligible to continue coverage under a separate contract with the group plan for up to **36 additional months.** Conversion coverage would then be available. You can keep your dependent children and adopted children/stepchildren on your family plan for as long as they are eligible (age, student status, etc.). *(See the CONTINUATION OF HEALTH COVERAGE section for further information.)*

When both parties in the domestic partnership are state or university employees or annuitants, and each party is eligible for state health insurance in his or her own right, and is insured under the state plan at the time of the termination, each retains the right to continue state health insurance coverage. Upon a termination of a domestic partnership, an affidavit must also be filed, in addition to an electronic or paper application.

The participant insured as a dependent under his or her former domestic partner's insurance must submit an electronic or paper application to establish coverage in his or her own name. The former domestic partner must continue coverage with the same plan unless he or she moves out of the service area (e.g., county). The application must be received by the employee's benefits/payroll/personnel office, or for annuitants by ETF, within **30 days** of receipt by ETF of the *Affidavit of Termination of the Domestic Partnership (ET-2372)*.

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

Note for active employees: Failure to apply in a timely manner will limit enrollment to the annual It's Your Choice Open Enrollment period for January 1, coverage.

Note for annuitants and continuants: Failure to apply in a timely manner will delay the effective date of coverage.

Medicare Eligibility

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

Death

(State and Annuitants only) Surviving Dependents. If an active or retired employee with family coverage dies, the surviving insured dependents shall have the right to continue coverage for life under the State of Wisconsin Group Health Insurance Program at group rates. The dependent children may continue coverage until eligibility ceases if they:

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

Health insurance coverage will automatically continue for your covered surviving dependents. Continued coverage will be effective on the first of the month after the deceased participant's date of death. Surviving dependents may voluntarily terminate the health insurance coverage by providing

written notification to ETF, and the coverage will terminate on the last day of the month in which their written request is received by ETF.

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

If family coverage was in force at the time of death, any unused sick leave credits in the deceased employee's account are available to the surviving dependents for premium payments. If sick leave credits are escrowed, the surviving dependents may continue to escrow the credits or may apply to convert the credits to pay health insurance premiums.

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

(Grad only) If family coverage was in force at the time of death, the covered surviving dependents are then eligible for COBRA Continuation. *(See Question 60. Who is eligible for continuation?)*.

22. When can I change from family to single coverage or single to family coverage?

If your employee premiums are deducted on a pre-tax basis under Internal Revenue Code Section 125 rules, switching from family to single coverage is not allowable unless there is an IRS qualified family status change. For example, all covered family members lose eligibility for health coverage or become eligible for and enroll in another group plan. If any covered dependents remain eligible for coverage, a change from family to single coverage is allowed only during the It's Your Choice Open Enrollment period.

If your employee premiums are deducted on a post-tax basis or you are an annuitant, you may change from family to single coverage at anytime. The change will be effective on the first day of the month on or following receipt of your electronic or paper application by your benefits/payroll/personnel office (ETF for annuitants and continuants). Switching from family to single coverage when you still have eligible dependents is deemed a voluntary cancellation of coverage for all covered dependents and is not considered a "qualifying event" for continuation coverage.

(State only) Please Note: If you have single coverage and you should die, your sick leave credits will not be available for use by your surviving dependents.

Changing from single to family coverage, regardless of whether your premiums are deducted on a pre- or post-tax basis, is only allowed during the It's Your Choice enrollment period, or when you or an eligible dependent has a qualifying event that allows for family coverage. See the *Frequently Asked Question* "If I do not change from single to family coverage during the It's Your Choice Open Enrollment period, will I have other opportunities to do so?" of the *It's Your Choice: Decision Guide.*

BENEFITS AND SERVICES

HEALTH PLAN INFORMATION

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

All changes in coverage are accomplished by completing an electronic or paper application within 30 days after the change occurs. An employee should file an application with your benefits/payroll/personnel office (ETF for annuitants and continuants). Failure to report changes on time may result in loss of benefits or delay payment of claims. *(See Question 19: Which changes need to be reported?)*:

- Change in plan (for example, from HMO to Standard Plan)
- Change in plan coverage (for example, from single to family)
- Name change
- Change of address or telephone number
- Addition/deletion of a dependent to an existing family plan

Exception: Some HMOs require that you notify them if you change your primary care physician. Contact your HMO for details.

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

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

Present your identification card to the hospital or physician who is providing the service. Identification numbers are necessary for any claim to be processed or service provided.

Most of the alternate plans also require that non-emergency hospitalizations be prior authorized and contact be made if there is an emergency admission. **In addition, beginning in 2013, prior authorization is required for high-tech radiology (for example, MRI, PET, CT scans) and for low back surgeries.** Check with your plan and make sure you understand all requirements.

For the Standard Plan and SMP, it is required that you or your physician contact the health plan before you are admitted to a hospital unless it is an emergency. In an emergency, you must notify the plan within two business days of the admission or as soon as reasonably possible.

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

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

26. How do I file claims?

Most of the services provided by an HMO do not require filing of

claim forms. However, you may be required to file claims for some items or services. The Standard Plan, SMP and for annuitants the Medicare Plus plan require claims incurred in any calendar year to be received by the administrator no later than the end of the next calendar year. Alternate plans (HMOs) require claims be filed within 12 months of the date of service or, if later, as soon as reasonably possible.

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

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

PROVIDER INFORMATION

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

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

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

29. How do I choose a primary physician or pharmacy that is right for me?

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

30. How do I know which providers are in-network providers?

See the plan description page in *It's Your Choice: Decision Guide* for more information on how to access or receive a provider directory. You may also contact the health plan administrator to receive a printed copy. Neither ETF nor your employer maintain a current list of this information.

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

Alternate plans (HMOs and PPOs such as WEA Trust PPO and WPS Metro Choice) differ in their policies. Contact your health plan to find out their requirements to make this change and when your change will become effective.

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

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

33. What happens if my provider leaves the plan midyear?

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

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

Your provider leaving the plan does not give you an opportunity to change plans midyear.

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

As an HMO or SMP participant, you are strongly recommended to designate a primary physician or clinic. Your primary physician is responsible for managing your health care. Under most circumstances, he or she may refer you to other medical specialists within the HMO's or SMP's provider network as he or she feels is appropriate. However, referrals outside of the network are strictly regulated. Check with your plan for their referral requirements and procedures.

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

PREMIUM CONTRIBUTION TIERING

35. How are health premium contributions determined? Why was a tiered premium contribution structure implemented?

(State and Grad only) For eligible employees, the employer contribution is determined either through collective bargaining or through the applicable compensation plan.

The three-tier health insurance program was implemented as an innovative approach that holds costs down as it creates incentives for

health plans to reduce their costs to the state, and encourages employees in the state to choose the plans that are most efficient in providing quality health care. Each plan is rated and placed in a tier based on efficiency. Plans in the same tier have been determined to be within certain thresholds in their level of efficiency.

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

(State and Grad only) No, all alternate plans (HMOs and WEA Trust PPOs and WPS Metro Choice's PPO) are required to offer the Uniform Benefits. Premium rates and tier placement may vary because of many factors: how efficiently the plan is able to provide services and process benefit payments; the fees charged in the area in which service is being rendered; the manner in which the health care providers deliver care and are compensated within the service area; and how frequently individuals covered by the plan use the health plan. Also, plans offering optional dental coverage may have slightly higher premiums. The Standard Plan will continue to offer benefits that differ from Uniform Benefits.

37. How often will premium rates change?

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

38. If a plan is not in the Tier 1, does that mean it provides lower quality health care?

(State and Grad only) No. The Group Insurance Board will not allow such a plan into the program. This is verified by our collection of data from the Consumer Assessment of Health Plans (CAHPS) survey, the Health Plan Employer Data and Information Set (HEDIS), and other quality measures. Plans that do not make Tier 1 placement are those that are less cost effective in managing care, costs and quality.

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

(State and Grad only) Premiums are paid in advance. Therefore, initial deductions from your salary probably may occur up to two months before coverage begins. If the initial deduction cannot occur that far in advance, double or triple deductions may be required initially to make premium payments current. If you have questions, contact your employer. **Note**: If eligible, your premiums will automatically be deducted from your payroll check on a pre-tax basis.

(Annuitants only) Premium rates for retired employees are the same as for active employees (except that your premium will decrease when you or a dependent becomes covered by Medicare). However, the state does not pay any portion.

Your monthly premiums will be paid in one of the following ways:

- **From your Accumulated Sick Leave Conversion Credits until those credits are exhausted.** If you have accumulated sick leave at the time of your retirement or death (and your applicable compensation

plan or collective bargaining agreement provides for sick leave conversion), the credits can be converted to a dollar amount to pay your health premiums for the State of Wisconsin Group Health Insurance Program. (Sick leave credits can only be converted for payment of State of Wisconsin Group Health Insurance Program premiums; they cannot be used for other insurance; they have no cash value and accrue no interest.) If you choose to escrow (preserve) your sick leave, this can be done at the time of retirement or a later date. Contact ETF for the escrow form.

NOTE: If you qualify for a WRS disability benefit, you have the option of being paid your sick leave hours or having them converted to pay your health premiums while you are receiving your disability annuity.

If you have no sick leave credits available or your credits are exhausted, then monthly premiums will be paid:

- **From deductions from your monthly retirement, disability or beneficiary annuity payment.** Premiums will be automatically deducted a month in advance of coverage. If there is no annuity or your annuity is not large enough to take premiums, then they will be paid:
- **From direct billings to you.** Your health plan will bill you directly for premiums on a monthly basis. **WARNING: Your coverage will be cancelled if you fail to pay your premium in a timely manner. If you re-enroll, coverage will be effective January 1 following enrollment during the It's Your Choice Open Enrollment period. If you are a surviving dependent, you are not eligible for re-enrollment.**
- **From your converted life insurance.** If you are retired and have life insurance coverage through the state of Wisconsin, are at least 66 and **have used up all your sick leave credits**, you may elect to convert your life insurance to pay health insurance premiums. If you make this election, your life insurance coverage will cease and you will receive credits in a conversion account equal to the present value of your life insurance. The present value ranges from about 44% to 80% of the face amount, depending on your age. The life insurance company, Minnesota Life, will pay health insurance premiums on your behalf from your conversion account until the account is exhausted. You will NOT receive any direct cash payment. You may file the election at anytime, and it will be effective no earlier than 61 days after ETF receives it. For more information, contact ETF.

40. Do I have to use my sick leave credits to pay my health premiums?

(Annuitants only) You do not have to use your sick leave credits to pay your health premiums if:

- **You escrow your sick leave**. If you are insured in the state program on your termination date, are eligible to use sick leave credits and are covered under comparable health coverage, you may escrow your sick leave credits. You may also

elect to escrow later if you become covered by a comparable health coverage when you are insured in the state program. You may escrow indefinitely as long as you have comparable health coverage continuously during the escrow period. You may elect coverage under any plan in the state program without waiting periods or exclusions for preexisting conditions when timely re-enrolled.

OR

- **You are covered under your spouse/domestic partner's State of Wisconsin Group Health Insurance Program plan.** If you retire and are also a dependent on your spouse/domestic partner's state group health insurance plan, you will have your sick leave credits inactivated until your spouse/domestic partner retires and depletes his or her own sick leave credits.

NOTE: You can unescrow your sick leave once a year during the It's Your Choice Open Enrollment period. (See *Sick Leave Conversion Credit Program brochure (ET-4132) for detailed information.)*

MEDICARE INFORMATION

If you are eligible for Medicare, you must be enrolled in the hospital (Part A) and medical (Part B) portions of Medicare at the time of your retirement. If you are an active employee, these requirements to enroll for Medicare coverage are deferred for you and your dependents until the termination of your employment. Because all plans that participate in the State of Wisconsin Group Health Insurance Program have coverage options that are coordinated with Medicare, you will remain covered by the plan you have selected even after you enroll in Medicare. Premium rates will decrease if Medicare covers you or a dependent, and you are retired. The plan will not duplicate benefits paid by Medicare. However, if enrolled in the Standard Plan or SMP, your coverage will change to the Medicare Plus plan when you enroll in Medicare Parts A and B. For all health plans, prescription drugs will continue to be covered.

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

For information about Medicare benefits, eligibility and how to enroll contact your local Social Security Administration office or call 1-800-772-1213. In addition, the State Health Insurance Assistance Program (SHIP) has counselors in every state and several territories who are available to provide free one-on-one help with your Medicare questions or problems. The Wisconsin SHIP can be reached at 1-800-242-1060. Additional information and assistance can be found at http://dhs.wisconsin.gov/aging/ebs/ship.htm. A list of SHIP programs outside of Wisconsin can be found at http://www.medicare.gov/contacts/staticpages/ships.aspx.

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

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

If you become eligible for Medicare,

your eligibility for COBRA coverage ends. Contact ETF for more information.

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

In general, enrollment in Medicare Part D (prescription drug coverage) is voluntary; however, you may pay a penalty if you do not enroll when you are first eligible or are not covered by what Medicare considers creditable coverage. Regardless, Medicare Part D coverage is provided by the State group health insurance program. Additional information about all parts of Medicare can be found in the following questions and answers.

(Grad only) There is no Medicare reduced rate available to those enrolled in the Graduate Assistant program.

42. When must I apply for Medicare?

(State and Annuitants only)

Medicare Part A

Most people become eligible for Medicare upon reaching age 65. Individuals who have been determined to be disabled by the Social Security Administration (SSA) become eligible after a 24-month waiting period.

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

Medicare Part B

The requirement to enroll in Medicare Part B coverage is deferred for active employees and their dependents until the subscriber's termination of their WRS-covered employment, through which active employee health insurance coverage is provided. If you have terminated employment, or are a surviving dependent, or a continuant and are eligible for coverage under the federal Medicare program, you must immediately enroll in both Part A and Part B of Medicare unless you are otherwise employed and have health insurance coverage through that employment. **If you do not enroll for all available portions of Medicare upon retirement, you may be liable for the portions of your claims that Medicare would have paid beginning on the date Medicare coverage would have become effective.**

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

For subscribers and their dependents with End Stage Renal Disease (ESRD).

You will want to contact your local Social Security office, health plan, provider and Medicare to make sure you enroll in Medicare Parts A and Part B at the appropriate time. The State of Wisconsin Group Health Insurance Program will provide primary coverage during the 30-month coordination period for members with ESRD. You will want to decide if it would be beneficial to enroll in Part B during your initial or general enrollment opportunities to avoid later delayed Medicare enrollment and potential premium penalties after your 30-month coordination period ends.

Medicare Part D

U.S. residents, retired members and their spouses, domestic partners and/or dependents that participate in the State group health insurance program who are Medicare enrolled, will be automatically enrolled in the ***Navitus Medicare Rx (PDP), Underwritten by Sterling Life Insurance Company***. The prescription drug coverage under this program is Medicare Part D coverage. Your monthly health insurance premium includes a portion that applies to this program's coverage.

Before Navitus can report your enrollment in Medicare Part D to Medicare, they need to have your Medicare Health Insurance Claim (HIC) number and Parts A & B effective dates. In most cases, ETF will request this information from you two to three months in advance of your 65th birthday by sending you a *Medicare Eligibility Statement* (ET-4307). ETF will then provide the information to Navitus. Please complete and return the ET-4307 as soon as possible to ensure you receive the benefits you are eligible for and your claims are paid properly.

If you do not receive the ET-4307 at least one month before your 65th birthday, please contact ETF. The form is also available at ETF's Internet site: etf.wi.gov/publications/et4307.pdf.

If you are retired and cover a Medicare-eligible spouse or disabled dependent on your plan, please notify ETF and provide your spouse's or dependent's Medicare information.

Individuals may choose to enroll in another Medicare Part D prescription drug plan; however, it is not recommended or required for your continued coverage under the State group health insurance program.

If you choose to enroll in a different Medicare Part D plan, your health insurance premium for the state plan does not change, but your ETF pharmacy coverage will be secondary to the other Medicare Part D plan. (See *Question 46: How does Medicare Part D affect my prescription drug coverage and should I enroll? and Question 47: Will my health insurance premium go down if I enroll in Medicare Part D prescription drug plan?*)

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

(Annuitants only) If Medicare is the primary insurance, your provider must submit claims to Medicare first. Once

Medicare processes the claim(s), Medicare will send you a quarterly Medicare Summary Notice (MSN).

Alternate Plans (HMOs and the PPOs—WEA Trust PPO and WPS Metro Choice):

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

Alternate Medicare Advantage Preferred Provider Organization (MA-PPO):

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

You must be enrolled in Medicare Parts A and B to be eligible for a health plan's MA-PPO. You should keep your Medicare card in a safe place, but you should not show it when you receive health care services, as the MA-PPO will be primary for your service.

(*See Question 45: If I have Medicare as my primary coverage, how are my benefits coordinated?*)

Humana currently offers this type of MA-PPO.

Medicare Plus:

Your responsibilities in the claims process will depend on the policies and practices of the medical facility from which you receive care. You may be required to submit the claims to Medicare and then submit the proper forms to WPS Health Insurance for supplemental payments. Refer to the *Medicare Plus (ET-4113)* benefit guide available from WPS or ETF for more information, and contact your health care provider or facility regarding their particular Medicare claims procedures.

Pharmacy Benefit Manager:

As long as you maintain the ***Navitus Medicare Rx (PDP), Underwritten By Sterling Life Insurance Company***, as your Medicare Part D plan, Navitus will process your claims for both Part D and the WRAP coverage.

However, if you choose to enroll in a Medicare Part D plan other than the ***Navitus Medicare Rx (PDP), Underwritten By Sterling Life Insurance Company*** plan, your State of Wisconsin Group Health Insurance Program pharmacy benefits will be considered secondary. Some, but not all, network pharmacies may be able to process the secondary claims electronically. However, you should be prepared to file the secondary claims manually through Navitus. Contact Navitus or visit their website for more information on filing

manual claims.

Medicare Part B pharmacy claims are covered under the WRAP benefit. For specific information on Medicare Part B pharmacy coverage and Part B claims processing, see *The Plan Description Page for Navitus™ Health Solutions* in the *It's Your Choice: Decision Guide.*

44. What is the Medicare Cross-over Option?

(Annuitants only) Medicare Cross-over is designed to eliminate some of the paperwork involved in filing medical claims. Some plans have an agreement with Medicare to crossover claims for any services that Medicare processed as primary. Medicare will automatically forward your Explanation of Medicare Benefits (EOMB) to those plans for services you receive throughout the United States. Claim forwarding is automatic for each person covered under Medicare when a plan participates in Medicare Cross-over. You do not need to complete a form or contact a plan to take advantage of crossover. Please contact your health plan for further information.

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

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

Exception: if you are enrolled in the Standard Plan or SMP, your coverage will be changed to the Medicare Plus plan. There are some differences in benefits between these plans. Medicare Plus is designed to supplement the benefits you receive under Medicare.

If you are enrolled in an alternate plan (HMO or PPO that offers Uniform Benefits), your health coverage will change as described in the Uniform Benefits section of the Guide. This type of coverage is called a carve-out plan. Your alternate plan supplements, not duplicates, the benefits you receive under Medicare. Because of this coordination with Medicare, your monthly premiums for state health insurance will be less. **Note:** For some benefits under Uniform Benefits, such as durable medical equipment, Medicare Part B and the health plan both have a 20% coinsurance that you are responsible to pay.

Humana offers Medicare Coordination Coverage through a Medicare Advantage Preferred Provider Organization (MA-PPO). As Medicare has contracted financial responsibility for medical benefit administration to this MA-PPO plan, all claims should be submitted to the MA-PPO. You must keep Medicare Part A and B coverage, but you will not need to show your Medicare card to your providers, instead show your MA-PPO card. Members who are direct billed by Humana will receive two bills that will add up to the total

amount due. Both bills must be paid monthly for coverage to continue.

This MA-PPO plan offers greater flexibility in provider selection than a traditional HMO for retirees over age 65 and on Medicare. For members under age 65 who are not on Medicare, you must comply with the health plan's network requirements.

If you are enrolled in MA-PPO, have Medicare Part A and B, and are no longer an active employee, your benefits will be modeled on Uniform Benefits, and include those of traditional Medicare. You have the freedom to choose providers. However, you will have greater out-of-pocket costs if you use out-of-network providers. Contact the MA-PPO for provider information.

MEDICARE PART D INFORMATION

46. Which Medicare Part D prescription drug coverage is provided under the State of Wisconsin Group Health Insurance Program?

Medicare related prescription drug coverage will be provided by Navitus Health Solutions (Navitus) through a self-funded, Medicare Part D Employer Group Waiver Plan (EGWP) called the Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company. This affects Medicare-eligible participants covered under an annuitant contract enrolled in the State of Wisconsin Group Health Insurance Program. As required by Uniform Benefits, a Wrap benefit is also included to mainly provide full coverage to State members when they reach the Medicare coverage gap, also known as the "donut hole." But the Wrap benefit will also provide coverage at other times when the EGWP does not, such as durning the Medicare Part D deductible and the initial coverage phases. Sterling has been contracted with the Centers for Medicare and Medicaid Services since 2006, when Medicare Part D was first implemented, to offer Medicare Part D prescription drug plans to employer groups.

Your group health insurance premium already includes the cost of this benefit. There is no separate premium that needs to be paid for this Medicare Part D coverage. It is important that you read and understand the information presented on the Navitus MedicareRx plan description page included in the *It's Your Choice: Decision Guide*.

47. How does Medicare Part D affect my prescription drug coverage? Should I enroll?

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

Under the State group health insurance program, after you become eligible for Medicare Part D the following will happen:

- You will be automatically enrolled in the ***Navitus Medicare Rx (PDP)*** plan. Medicare eligible spouses,

domestic partners and/or dependents will also be enrolled. This is Medicare Part D coverage. **Your group health insurance premium already includes the cost of this Medicare Part D coverage.**

- You will also be automatically enrolled for secondary Wrap coverage to ensure your prescription drugs are covered when you reach the Medicare Part D coverage gap, commonly referred to as the "donut hole." **Your group health insurance premium already includes the cost of this Wrap coverage.**

WHEN YOU ARE ENROLLED IN THE Navitus Medicare Rx (PDP) plan, YOU WILL BE ISSUED A NEW ID CARD THAT YOU WILL BE REQUIRED TO USE.

If you would like to maintain your current level of prescription drug benefits under our program, it is not necessary to enroll in another Medicare Part D plan. Nevertheless, participation in a Medicare Part D prescription drug plan is voluntary and you should carefully consider all options before making any kind of decision to enroll in a different Medicare Part D plan.

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

(Annuitants only) No. Your health insurance premium includes both medical and prescription drug coverage. If you choose to enroll in a different Medicare Part D plan, you will be dropped from the ***Navitus Medicare Rx (PDP)*** plan and you will have to pay an additional premium to the other plan you enroll in. However, you will still have secondary coverage with the Wrap benefits under the State group health insurance program. **There is no partial refund of the State group health insurance premium if you choose to enroll in a different PDP.** Navitus will coordinate coverage with Medicare and pay secondary claims after Medicare processes your prescription claims from the other Medicare Part D plan, minus the applicable copayments and coinsurance that are your responsibility. **If you enroll in another Medicare Part D plan before January 1, 2013, for coverage in 2013, and you intend to stay in that program, notify ETF immediately. If ETF enrolls you in Navitus MedicareRx, you will be automatically disenrolled from your other plan by CMS.**

PHARMACY BENEFITS MANAGER (PBM)

49. What is a Pharmacy Benefit Manager

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

50. What is a formulary? How is it developed? How will I know if my prescription drug is on it?

A formulary, which is established by a committee of physicians and pharmacists, is a list of prescription drugs that are determined to be both medically effective and cost-effective.

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

The complete formulary can be found on Navitus' website, www.navitus.com through Navi-Gate for members. Just click on **Members-Your Formulary** under the "Quick Links" section to log in, and then select the formulary named "State of WI and WI Public Employers (administered through ETF) Formulary." You may also call Navitus Customer Care toll free at 1-866-333-2757 with questions about the formulary.

51. How does a four-level drug copayment system work?

Under a four-level prescription drug benefit, you have four different copayment amounts for covered prescription drugs. By having to pay a lower copayment for Level 1 and Level 2 drugs, you are encouraged to use the preferred formulary drugs. Drugs that are listed on the formulary at the Level 3 copayment are considered non-formulary drugs but are still covered if you wish to use them and pay the higher copayment. This gives you more freedom of choice with the drugs that you are prescribed. Level 4 drugs are Specialty Medications that have the highest copayment and are also classified as either formulary or non-formulary drugs. Formulary Specialty Medications may have a reduced copayment if the prescription is filled at the preferred participating phamacy for Specialty Medications (Diplomat Specialty Pharmacy). The copayments for Level 1 and 2 (formulary) drugs are applied to your annual Level 1/Level 2 out-of-pocket-limit (OOPL). The copayments for formulary Specialty Medications are applied to your Level 4 OOPL, which is separate from the Level 1/Level 2 OOPL. The copayment of Level 3 drugs and non-formulary Specialty Medications do not count toward any OOPL.

Under the four-level prescription drug benefit, it may still be necessary to get a prior authorization before some formulary and non-formulary drugs will be covered.

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

Yes, you will have two identification cards; one from your health plan, and one from either (a) Navitus Health Solutions or (b) the Navitus Medicare Rx (PDP), Underwritten By Sterling Life Insurance Company plan (for eligible retirees enrolled in Medicare) for pharmacy benefits. Your member identification number will be different on each card, so it is important that you show the correct card when getting services. When filling prescriptions, you **must** present your pharmacy benefits ID card to the pharmacist.

CHANGING HEALTH PLANS

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

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

- Move from your plan's service area (for example, out of the county) for

a period of at least **3 months.** Your new coverage will be effective subsequent to your move. You may again change plans when you return for **3 months** by submitting another application within **30 days** after your return. (See *Question 54: What if I have a temporary or permanent move from the service area?*)

- You involuntarily lose eligibility for other coverage or lose the employer contribution for it.
- You add one or more dependents due to marriage, domestic partnership, birth, adoption or placement for adoption.

NOTE:

- **(State and Grad only)** If your premiums are being deducted on a pre-tax basis, you may cancel coverage mid-year only if you are cancelling because you have become eligible for and enroll in other group coverage or terminate employment. Otherwise, you can only change health plans without restriction during each It's Your Choice Open Enrollment period and coverage will be effective the following January 1. If your premiums are being deducted post-tax, you may cancel coverage at anytime.

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

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

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

A subscriber who moves out of a service area (for example, out of the county), either permanently or temporarily for **3 months** or more, will be permitted to enroll in the Standard Plan or an available alternate plan that offers in-network providers near you, provided an electronic or paper application for such plan is submitted within **30 days** after relocation. You will be required to document the fact that your application is being submitted due to a change of residence out of a service area.

If your relocation is temporary, you may again change plans by submitting an application within **30 days** after your return. The change will be effective on the first of the month on or after your application is received by your employer or by ETF, but not prior to your return.

(State and Grad only) It is important that your submit your electronic or paper application to change coverage as soon as possible and no later than **30 days** after the change of residence to maintain coverage for non-emergency services. The change in plans will be effective on the first day of the month on or after your application is received by your

employer but not prior to the date of your move. If your application is received after the **30-day** deadline, you will not be allowed to change plans until the following It's Your Choice Open Enrollment period or in certain situations. *(See Frequently Asked Question 9. Are there other enrollment opportunities available to me after my initial one expires?)*

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

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

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

CANCELLATION/ TERMINATION OF COVERAGE

57. How do I cancel coverage?

Voluntary cancellation (or switching from family to single coverage which is deemed voluntary cancellation for all insured dependents) requires written notification to the employer and the completion of an application electronically or via paper denoting a cancellation of coverage.

If your premiums are being deducted on a pre-tax basis, you may cancel coverage only if you are canceling because you become eligible for and enroll in another group plan, terminate employment, or are enrolling during the annual It's Your Choice period.

If your adult dependent child becomes eligible for and enrolled in other group health insurance coverage, and you want to drop coverage for him/her, you must submit an application electronically or via paper to your employer (to ETF for annuitants) within 30 days of the effective date of other coverage. In addition, you must submit proof of enrollment such as an ID card from that coverage. If this is your last dependent and you want to change to single coverage, you must note that on your application.

If your spouse/domestic partner becomes eligible for and enrolled in other group health insurance coverage, and you want to change

to single coverage or cancel your family coverage, you must submit an application electronically or via paper to your employer (to ETF for annuitants) within 30 days of the effective date of other coverage. In addition, you must submit proof of enrollment such as an ID card that lists all individuals covered under that plan.

If your premiums are being deducted post-tax, you may cancel at anytime.

Be aware that voluntary cancellation of coverage does not provide an opportunity to continue coverage for previously covered dependents as described in the CONTINUATION OF HEALTH COVERAGE section. Cancellation affects both medical and prescription drug coverage.

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

58. When can my health insurance coverage be terminated?

Your coverage can only be terminated because:

- Premiums are not paid by the due date. Coverage is also waived (known as "constructive waiver") when the employee portion of the premium is not deducted for 12 consecutive months.
- Coverage is voluntarily cancelled.
- Death of the subscriber.
- Fraud is committed in obtaining benefits or there is an inability to establish a physician/patient relationship. Termination of coverage for this reason requires Group Insurance Board approval.

(State and Grad only) Your coverage can be terminated because your eligibility for coverage ceases (for example, termination of employment).

(Annuitants only) Your coverage can be terminated because you:

- Failed to apply for both Medicare Part A and B when first eligible. The Medicare enrollment requirement is deferred while you or your spouse/ domestic partner are employed and covered under a group health insurance plan from that employment. (See *Question 42: When must I apply for Medicare?*)
- Became ineligible for coverage as an annuitant because of becoming an active WRS employee. (See *Question 11: How are my health benefits affected by my return to work for an employer who is under the WRS?*)

Active employees should contact their benefits/payroll/personnel office (annuitants and continuants should contact ETF) for the date coverage will end.

59. Is it possible to enroll or re-enroll in this health insurance program after I terminate state employment?

(State and Annuitants only) If you terminate state employment

and you are not enrolled for health insurance or subsequently terminate coverage, you may enroll for single or family coverage if you are:

1. A retired employee of the state who is receiving a retirement annuity or has received a lump sum payment under Wis. Stat. § 40.25 (1); or
2. An employee of the state who terminates service after attaining 20 years of creditable service, remains a WRS participant and is not eligible for an immediate annuity.

If you are eligible, you must submit an electronic or paper application to enroll during the It's Your Choice Open Enrollment period and may select any offered health plan. Surviving dependents are not eligible for this enrollment.

60. Is there any state contribution for health insurance after I terminate coverage?

(State only) Yes. Under certain circumstances, your accumulated unused sick leave can be converted to credits to pay for health insurance premium if you are:

- Retiring;
- Terminating after accumulating 20 years of creditable WRS service; or
- Surviving dependents who are insured under our program at the time of the active subscriber's death.

The rules governing eligibility are described in ETF publications ET-4112, ET-4116 and ET-2119.

CONTINUATION OF HEALTH COVERAGE

61. Who is eligible for continuation?

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

(State and Grad only)

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

health plan will bill you directly. There can be no lapse in coverage, so multiple premiums may be required.

- If you terminate employment and have less than 20 years of creditable service, you will be offered an 18 month continuation coverage period. **A second qualifying event while on continuation will not serve to extend your period of continuation. Coverage will be limited to the original 18 months.** At the end of the continuation period, you will be allowed to enroll in an individual conversion through the health plan.

NOTE: Continuation coverage time limits do not apply to state and university employees who terminate with 20 years of WRS creditable service and remain a WRS participant. They can continue the group health insurance for life even if they don't take an immediate annuity. To continue, an application must be received before coverage lapses.

62. When my dependent loses eligibility, is he/she eligible for COBRA? What do I need to do to ensure COBRA coverage if offered?

You will need to report this change to your benefits/payroll/personnel office (or ETF for annuitants and continuants) within 60 days of your dependent losing his/her eligibility to ensure COBRA coverage is offered. Your dependent will be entitled to 36 months of continuation coverage.

63. Does my coverage change under continuation?

No, continuation coverage is identical to the active employee coverage.

In most cases, you are eligible to maintain continuation coverage for **18 months** from the month of the qualifying event. These events are termination of employment or reduction in work hours. Events such as death of employee, divorce or the loss of eligibility for a dependent child entitles the dependent to **36 months** of coverage. You are allowed to change plans during the annual It's Your Choice Open Enrollment period or if the subscriber moves from the service area. However, your continuation coverage may be cut short for any of the following reasons:

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

If you or your covered dependent becomes eligible for Medicare, you may need to enroll in Medicare as soon as you are eligible. (See *Question 42: When Must I Apply for Medicare?*)

64. Will my premium change under continuation?

If you are an active employee your premium may change as you will pay the total premium amount which includes both the employee and employer share. Contact your

benefits/payroll/personnel office to obtain the total amount.

If you are an annuitant or continuant you will want to refer to the premium rates listed in the Health Plan Premium Rates Section of the *It's Your Choice: Decision Guide.*

65. How do I cancel continuation coverage?

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

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

If you move out of the service area (either permanently or temporarily for 3 months or more), you are eligible to change plans. (See *Question 54: What if I have a temporary or permanent move from the service area?*)

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

67. When is conversion coverage available?

As required by law, you are eligible to apply for conversion coverage when group continuation coverage terminates. Contact the plan directly to make application for conversion coverage. Conversion coverage is available without providing evidence of insurability and with no waiting period for preexisting conditions, provided state group coverage has been in effect for at least **3 months** prior to termination.

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

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

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

CERTIFICATE OF COVERAGE

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

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

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Uniform Benefits: State Participants 2013

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

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

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

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Uniform Benefits Quick Reference Guide *118*

I. SCHEDULE OF BENEFITS

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

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

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

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

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

Schedule of Benefits: State Participants 2013

Benefit	State of Wisconsin eligible Participants who are not eligible for nor enrolled in Medicare as the primary payer	Medicare prime Retired State of Wisconsin eligible Participants
Annual Medical Coinsurance	90%/10% except as described below. Coinsurance applies to Out-of-Pocket-Limit (OOPL) except as described below.	100% except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.
Annual Medical Out-of-Pocket Limit (OOPL)	$500 Participant/$1,000 aggregate family limit except as described below.	None except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.
Routine, preventive services as required by federal law	100%*	100%
Illness/injury related services	90% (10% member cost to OOPL)	100%
Emergency Room Copay (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	$75 does not accumulate to OOPL, after copay 90% (10% member cost to OOPL)	$60
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% (20% member cost to OOPL)	80% to an annual OOPL of $500 per Participant; no aggregate family limit (20% member cost to OOPL)
Cochlear Implants for Participants age 18 and older	90% hospital charges. (10% member cost to OOPL) 80% device, surgery for implantation, follow-up sessions to train on use. (20% member cost does not apply to OOPL)	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use. (20% member cost does not apply to OOPL)
Cochlear Implants Participants under age 18	As required by Wis. Stat. §632.895 (16), 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)	100% hospital, device, surgery for implantation and follow-up sessions to train on use.
Hearing Aids for Participants age 18 and older. One aid per ear no more than once every 3 years.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.
Hearing Aids for Participants under age 18	As required by Wis. Stat. §632.895 (16), 90% (10% member cost to OOPL).	As required by Wis. Stat. §632.895 (16), 100%

*As required by federal law.
See http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html. Note, coinsurance can vary by age.

- Policy Coinsurance and medical Copayments: described below
- Policy Deductible: NONE
- Lifetime Maximum Benefit on All Medical and Pharmacy Benefits: NONE
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: NONE
- Outpatient Physical, Speech and Occupational Therapy Maximum: Covered up to 50 visits per Participant for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be available when Prior Authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per Participant per calendar year.
- Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan, and hospital charges for the surgery. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket limit. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable as described in the preceding grid.
- Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum payment of $1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket limit. As required by Wis. Stat. §632.895 (16), hearing aids for Participants under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.
- Home Care Benefits Maximum: 50 visits per Participant per calendar year. 50 additional Medically Necessary visits per Participant per calendar year may be available when authorized by the Health Plan.
- Hospice Care Benefits: Covered when the Participant's life expectancy is six months or less, as authorized by the

Health Plan.

- Transplants: Limited to transplants listed in Benefits and Services section.
- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.
- Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.
- Vision Services: One routine exam per Participant per calendar year. Non-routine eye exams are covered as Medically Necessary. (Contact lens fittings are not part of the routine exam and are not covered.)
- Oral Surgery: Limited to procedures listed in Benefits and Services section.
- Temporomandibular Disorders: The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per Participant per calendar year. Intraoral splints are subject to the Durable Medical Equipment Coinsurance (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.
- Dental Implants: Following accident or injury, up to a maximum payment of $1,000 per tooth.
- Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services section. However, each Health Plan may choose to provide a dental plan to all of its members.

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

- Prescription Drugs and Insulin: (Except Specialty Medications)

Copayments

Level 1 Copayment for Formulary Prescription Drugs: $ 5.00

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

Level 2 Copayment for Formulary Prescription Drugs: $15.00

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

Level 3	Copayment for Covered Non-Formulary Prescription Drugs:	$35.00

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

Level 1/Level 2 Annual Out-of-Pocket Limit (The amount You pay for Your Level 1 and Level 2 prescription drugs and insulin):

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

Specialty Medications

Note: The specialty prescription drug pharmacy with which the PBM is contracted shall be considered the preferred Participating Pharmacy for Specialty Medications.

Copayments:

Level 4	Copayment for Formulary and Covered, Non-Formulary Specialty Medications; $50.00

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

Non-Formulary Specialty Medications: the Level 4 Copayment applies whether medications are obtained at the preferred Participating Pharmacy or another Participating Pharmacy. Level 4 copayments for non-Formulary Specialty medications do not accumulate toward any annual OOPL. You must continue to

pay copayments for Level 4 Non-Formulary Specialty Medications even after other annual OOPLs have been met.

Reduced Level 4 Copayment for Formulary Specialty Medications obtained from the preferred Participating Pharmacy: $15.00

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

Level 4 Annual Out-of-Pocket Limit (OOPL) (The amount You pay for Your Level 4 Specialty Medications.)

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

- Certain grandfathered erectile dysfunction medication as defined by the PBM (Viagra and Caverject Injection): the $50 Level 4 Copayment applies to these prescription medications. However, the copayments do **not** accumulate toward any OOPL. You must continue to pay Level 4 copayments for these drugs even after other annual OOPLs have been met.
- Disposable Diabetic Supplies and Glucometers Coinsurance: Payable at 80%, which will be applied to the prescription drug Level 1/Level 2 annual OOPL.
- Smoking Cessation: One consecutive three-month course of pharmacotherapy covered per calendar year. Prior authorization is required if the first quit attempt is extended by the prescriber.

II. DEFINITIONS

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

- **BED AND BOARD:** Means all Usual and Customary Hospital charges for: (a) Room and meals; and (b) all general care needed by registered bed patients.
- **BENEFIT PERIOD:** Means the total duration of Confinements that are separated from each other by less than 60 days.
- **BRAND NAME DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and Generic Drug classifications.
- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.
- **CONFINEMENT/CONFINED:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA residential center, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of Your physician; and discharge therefrom, or (b) the time spent receiving Emergency Care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement. Charges for Hospital or other institutional Confinements are incurred on the date of admission. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.
- **CONGENITAL:** Means a condition which exists at birth.
- **COINSURANCE:** A specified percentage of the charges that the Participant or family must pay each time those covered services are provided, subject to any limits specified in the Schedule of Benefits.
- **COPAYMENT:** A specified dollar amount that the Participant or family must pay each time those covered services are provided, subject to any limits specified in the Schedule of Benefits.
- **CUSTODIAL CARE:** Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a Plan Provider, has reached the maximum level of recovery. Custodial Care is provided to Participants who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered Custodial Care if the Participant is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the Plan Provider, that the

medical or surgical treatment will enable that person to live outside an institution. Custodial Care also includes rest cures, respite care, and home care provided by family members.

- **DEPARTMENT:** Means, Department of Employee Trust Funds.
- **DEPENDENT:** Means, as provided herein, the Subscriber's:
  - Spouse.
  - Domestic Partner, if elected.
  - Child.
  - Legal ward who becomes a legal ward of the Subscriber, Subscriber's spouse or insured Domestic Partner prior to age 19, but not a temporary ward.
  - Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
  - Stepchild.
  - Child of the Domestic Partner insured on the policy.
  - Grandchild if the parent is a Dependent child.

1. A grandchild ceases to be a Dependent at the end of the month in which the Dependent child (parent) turns age 18.
2. A spouse and a stepchild cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment. A Domestic Partner and his or her children cease to be Dependents at the end of the month in which the domestic partnership is no longer in effect.
3. All other children cease to be Dependents at the end of the month in which they turn 26 years of age, except that:

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

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

4. A child born outside of marriage becomes a Dependent of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The Effective Date of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.
5. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.
6. Any Dependent eligible for benefits who is not listed on an application for coverage will be provided benefits based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the employer, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

- **DOMESTIC PARTNER:** Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:
  - Each individual is at least 18 years old and otherwise competent to enter into a contract.
  - Neither individual is married to, or in a domestic partnership with, another individual.
  - The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.
  - The two individuals consider themselves to be members of each other's immediate family.
  - The two individuals agree to be responsible for each other's basic living expenses.
  - The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:
    - Only one of the individuals has legal ownership of the residence.
    - One or both of the individuals have one or more additional residences not shared with the other individual.
    - One of the individuals leaves the common residence with the intent to return.
- **EFFECTIVE DATE:** The date, as certified by the Department and shown on the records of the Health Plan and/or PBM, on which the Participant becomes enrolled and entitled to the benefits specified in the contract.
- **ELIGIBLE EMPLOYEE:** As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.
- **EMERGENCY:** Means a medical condition that manifests itself by

acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of medical attention will likely result in any of the following:

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

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

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

that determines brand and generic classifications.

- **GENERIC EQUIVALENT:** Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.
- **GRIEVANCE:** Means a written complaint filed with the Health Plan and/or PBM concerning some aspect of the Health Plan and/or PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.
- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during the calendar year.
- **HOSPICE CARE:** Means services provided to a Participant whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the Participant as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care Provider approved by the Health Plan.
- **HOSPITAL:** Means an institution that:

  1. (a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, Injury and Illness; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses; or
  2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare Provider; and (c) is accredited as a Hospital by the Joint Commission of Accreditation of Hospitals.

  The term Hospital does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal Hospital.
- **HOSPITAL CONFINEMENT** or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a Hospital on the advice of a Plan Provider; or (b) receiving Emergency care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility.
- **ILLNESS:** Means a bodily disorder, bodily Injury, disease, mental disorder, or pregnancy. It includes Illnesses which exist at the same time, or which occur one after the other but are due to the same or related causes.
- **IMMEDIATE FAMILY:** Means the Dependents, parents, brothers and sisters of the Participant and their spouses or Domestic Partners.
- **INJURY:** Means bodily damage that results directly and independently of all other causes from an accident.
- **LEVEL "M" DRUG:** Means a prescription medication designated by the PBM and covered by Medicare Parts B and D when the MEDICARE PRESCRIPTION

DRUG PLAN is the primary payer. LEVEL M DRUGS are required to be listed on the MEDICARE PRESCRIPTION DRUG PLAN's Medicare Part D formulary but are not included on the commercial coverage formulary. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the HEALTH PLAN.

- **MAINTENANCE CARE:** Means ongoing care delivered after an acute episode of an Illness or Injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Care" is made by the Health Plan after reviewing an individual's case history or treatment plan submitted by a Provider.
- **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT:** Means items which are, as determined by the Health Plan:
  1. Used primarily to treat an illness or injury; and
  2. Generally not useful to a person in the absence of an illness or injury; and
  3. The most appropriate item that can be safely provided to a Participant and accomplish the desired end result in the most economical manner; and
  4. Prescribed by a Provider.
- **MEDICALLY NECESSARY:** A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM:
  1. consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; and
  2. appropriate under the standards of acceptable medical practice to treat that Illness or Injury; and
  3. not solely for the convenience of the Participant, physician, Hospital or other health care Provider; and
  4. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.
- **MEDICARE:** Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
- **MEDICARE PRESCRIPTION DRUG PLAN:** means the prescription drug coverage provided by the PBM to COVERED INDIVIDUALS who are enrolled in Medicare Parts A and B, and eligible for Medicare Part D; and who are covered under a Medicare coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.
- **MEDICAID:** Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security

Amendments of 1965 as now or hereafter amended.

- **MISCELLANEOUS HOSPITAL EXPENSE:** Means Usual and Customary Hospital ancillary charges, other than Bed and Board, made on account of the care necessary for an Illness or other condition requiring inpatient or outpatient hospitalization for which Plan Benefits are available under this Health Plan.
- **NATURAL TOOTH:** Means a tooth that would not have required restoration in the absence of a Participant's trauma or Injury, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.
- **NON-PARTICIPATING PHARMACY:** Means a pharmacy who does not have a signed agreement and is not listed on the most current listing of the PBM's provider directory of Participating Pharmacies.
- **NON-PLAN PROVIDER:** Means a Provider who does not have a signed participating Provider agreement and is not listed on the most current edition of the Health Plan's professional directory of Plan Providers. Care from a Non-Plan Provider requires prior authorization from the Health Plan unless it is an Emergency or Urgent Care.
- **NUTRITIONAL COUNSELING:** This counseling consists of the following services:

  1. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician
  2. Re-assessment and intervention (individual and group)
  3. Diabetes outpatient self-management training services (individual and group sessions)
  4. Dietitian visit

- **OUT-OF-AREA SERVICE:** Means any services provided to Participants outside the Plan Service Area.
- **PARTICIPANT:** The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.
- **PARTICIPATING PHARMACY:** A pharmacy who has agreed in writing to provide the services that are administered by the PBM and covered under the policy to Participants. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a Participant. The PBM agrees to give You lists of Participating Pharmacies.
- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

- **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.

- **PLAN DEPENDENT:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.

- **PLAN PROVIDER:** A Provider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Participants. The Provider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a Participant. The Health Plan agrees to give You lists of affiliated Providers. Some Providers require Prior Authorization by the Health Plan in advance of the services being provided.

- **PLAN SERVICE AREA:** Specific zip codes in those counties in which the affiliated physicians are approved by the Health Plan to provide professional services to Participants covered by the Health Plan.

- **POSTOPERATIVE CARE:** Means the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.

- **PREOPERATIVE CARE:** Means the medical evaluation of a Participant prior to a covered surgical procedure. It is the immediate preoperative visit in the Hospital, or elsewhere, necessary for the physical examination of the Participant, the review of the Participant's medical history and assessment of the laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.

- **PRIMARY CARE PROVIDER:** Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Health Plan's health care system. He/She also (a) evaluates the Participant's total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other Provider health services and refers the Participant to other Providers.

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

- **PRIOR AUTHORIZATION:** Means obtaining approval from Your Health Plan before obtaining the services. Unless otherwise indicated by Your Health Plan, Prior Authorization is required for care from any Non-Plan Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan and are described in the Health Plan Descriptions section, of the "*It's Your Choice: Decision Guide.*" Some prescriptions may also require Prior

Authorization, which must be obtained from the PBM and are at its discretion.

- **PROVIDER:** Means (a) a doctor, Hospital, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Plan Benefits.
- **REFERRAL:** When a Participant's Primary Care Provider sends him/her to another Provider for covered services. In many cases, the Referral must be in writing and on the Health Plan Prior Authorization form and approved by the Health Plan in advance of a Participant's treatment or service. Referral requirements are determined by each Health Plan and are described in the Health Plan Descriptions section, of the "*It's Your Choice: Decision Guide.*" The authorization from the Health Plan will state: a) the type or extent of treatment authorized; and b) the number of Prior Authorized visits and the period of time during which the authorization is valid. In most cases, it is the Participant's responsibility to ensure a Referral, when required, is approved by the Health Plan before services are rendered.
- **SCHEDULE OF BENEFITS:** The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the Health Plan You elected.
- **SELF-ADMINISTERED INJECTABLE:** Means an injectable that is administered subcutaneously and can be safely self-administered by the Participant and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.
- **SKILLED CARE:** Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving Skilled Care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, "Skilled Care" is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, Domestic Partners, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require "Skilled Care" and are considered Custodial.
- **SKILLED NURSING FACILITY:** Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a Skilled Nursing Facility.

- **SPECIALTY MEDICATIONS:** Means medications that require special storage and handling and, as a result, are more costly and usually not available from all Participating Pharmacies.
- **STATE:** Means the State of Wisconsin as the policyholder.
- **SUBSCRIBER:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose

  Dependents are thus eligible for benefits.
- **URGENT CARE:** Means care for an accident or Illness which is needed sooner than a routine doctor's visit. If the accident or Injury occurs when the Participant is out of the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider. Urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.
- **USUAL AND CUSTOMARY CHARGE:** An amount for a treatment, service or supply provided by a Non-Plan Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related charges) prior to receiving services. Health Plan approved Referrals to Non-Plan Providers are not subject to Usual and Customary Charges. However, Emergency or urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.
- **YOU/YOUR:** The Subscriber and his or her covered Dependents.

III. BENEFITS AND SERVICES

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

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

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

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

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

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

A. Medical/Surgical Services

1. Emergency Care

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

b. You should use Plan Hospital emergency rooms whenever possible. If You are not able to reach Your Plan Provider, go to the nearest appropriate medical facility. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You received Emergency care. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan. In addition to cost sharing described in the Schedule of Benefits, Emergency care from

Non-Plan Providers may be subject to Usual and Customary Charges.

c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

d. Emergency services include reasonable accommodations for repair of Durable Medical Equipment as Medically Necessary.

e. Some examples of Emergencies are:
   - Acute allergic reactions
   - Acute asthmatic attacks
   - Convulsions
   - Epileptic seizures
   - Acute hemorrhage
   - Acute appendicitis
   - Coma
   - Heart attack
   - Attempted suicide
   - Suffocation
   - Stroke
   - Drug overdoses
   - Loss of consciousness
   - Any condition for which You are admitted to the Hospital as an inpatient from the emergency room

2. Urgent Care

a. Medical care received in an Urgent Care situation as defined in section II. URGENT CARE IS NOT EMERGENCY CARE. It does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.

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

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

3. Surgical Services

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

4. Reproductive Services and Contraceptives

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

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

b. Elective sterilization.

c. Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

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

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

5. Medical Services

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

a. Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

b. Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

c. Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

d. Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).

e. Medically Necessary travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the Participant by the Health Plan. It does not apply to travel required for work. (See Exclusion A., 2., e.)

f. Injectable and infusible medications, except for Self-Administered Injectable medications.

g. Nutritional Counseling provided by a participating registered dietician or Plan Provider.

h. A second opinion from a Plan Provider or when Prior Authorized by the Health Plan.

i. Preventive services as required by the federal Patient Protection and Affordable Care Act.

6. Anesthesia Services

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

7. Radiation Therapy and Chemotherapy

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

8. Detoxification Services

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

9. Ambulance Service

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

10. Diagnostic Services

Medically Necessary testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations. Prior authorization is required for referrals to Orthopedists and Neurosurgeons associated directly or indirectly with the plan for members 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 referral.

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

11. Outpatient Physical, Speech and Occupation Therapy

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

12. Home Care Benefits

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

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

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

physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

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

1) Hospital Confinement or Confinement in a Skilled Nursing Facility would be needed if home care were not provided.

2) The Participant's Immediate Family, or others living with the Participant, cannot provide the needed care and treatment without undue hardship.

3) A state licensed or Medicare certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

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

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

13. Hospice Care

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

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

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

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

14. Phase II Cardiac Rehabilitation

Services must be approved by the Health Plan and provided in an outpatient department of a Hospital,

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

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

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

16. Oral Surgery

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

a. Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c. Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d. Surgical procedures required to correct accidental Injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such Injuries are incurred while the Participant is continuously covered under this contract or a preceding contract provided through the Board.

e. Apicoectomy. (Excision of apex of tooth root.)

f. Excision of exostoses of the jaws and hard palate.

g. Intraoral and extraoral incision and drainage of cellulitis.

h. Incision of accessory sinuses, salivary glands or ducts.

i. Reduction of dislocations of, and excision of, the temporomandibular joints.

j. Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related Medically Necessary guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

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

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

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

17. Treatment of Temporomandibular Disorders

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

a. A Congenital, developmental or acquired deformity, disease or Injury caused the condition.

b. The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care Provider rendering the service.

c. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

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

18. Transplants

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

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

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

- Aplastic anemia

- Acute leukemia
- Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies
- Wiskott-Aldrich syndrome
- Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
- Hodgkins and non-Hodgkins lymphoma
- Combined immunodeficiency
- Chronic myelogenous leukemia
- Pediatric tumors based upon individual consideration
- Neuroblastoma
- Myelodysplastic syndrome
- Homozygous Beta-Thalassemia
- Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
- Multiple Myeloma, Stage II or Stage III
- Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b. Parathyroid transplantation

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

d. Corneal transplantation (keratoplasty) limited to:
   - Corneal opacity
   - 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
   - Corneal ulcer
   - Repair of severe lacerations

e. Heart transplants will be limited to the treatment of:
   - Congestive Cardiomyopathy
   - End-Stage Ischemic Heart Disease
   - Hypertrophic Cardiomyopathy
   - Terminal Valvular Disease
   - Congenital Heart Disease, based upon individual consideration
   - Cardiac Tumors, based upon individual consideration
   - Myocarditis
   - Coronary Embolization
   - Post-traumatic Aneurysm

f. Liver transplants will be limited to the treatment of:
   - Extrahepatic Biliary Atresia
   - Inborn Error of Metabolism
     Alpha -1- Antitrypsin Deficiency
     Wilson's Disease
     Glycogen Storage Disease
     Tyrosinemia
   - Hemochromatosis
   - Primary Biliary Cirrhosis
   - Hepatic Vein Thrombosis
   - Sclerosing Cholangitis

- Post-necrotic Cirrhosis, Hbe Ag Negative
- Chronic Active Hepatitis, Hbe Ag Negative
- Alcoholic Cirrhosis, abstinence for six or more months
- Epithelioid Hemangioepithelioma
- Poisoning
- Polycystic Disease

g. Kidney/pancreas, heart/lung, and lung transplants as determined to be Medically Necessary by the Health Plan.

h. In addition to the above-listed diagnoses for covered transplants, the Health Plan may Prior Authorize a transplant for a non-listed diagnosis if the Health Plan determines that the transplant is a Medically Necessary and a cost effective alternate treatment.

i. Kidney Transplants. See item 19 below.

19. Kidney Disease Treatment

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

20. Chiropractic Services

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

21. Women's Health and Cancer Act of 1998

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

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

22. Smoking Cessation

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

B. Institutional Services

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

1. **Inpatient Care**

   a. Hospitals and Specialty Hospitals: Covered for semi-private room, ward or intensive care unit and Medically Necessary Miscellaneous Hospital Expenses, including prescription drugs administered during the Confinement. A private room is payable only if Medically Necessary for isolation purposes as determined by the Health Plan.

   b. Licensed Skilled Nursing Facility: Must be admitted within 24 hours of discharge from a general Hospital for continued treatment of the same condition. Care must be Skilled. Custodial Care is excluded. Benefits limited to the number of days specified in the Schedule of Benefits. Benefits include prescription drugs administered during the Confinement. Confinement in a swing bed in a Hospital is considered the same as a Skilled Nursing Facility Confinement.

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

2. **Outpatient Care**

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

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

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

   Surgical Care: Covered.

C. Other Medical Services

1. **Mental Health Services/Alcohol and Drug Abuse**

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

   a. Outpatient Services

      Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. The outpatient services means non-residential services by Providers as defined and set forth under Wis. Stat. § 632.89 (1) (e). and as required by Wis. Adm. Code § INS 3.37.

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

   b. Transitional Services

      Covers Medically Necessary

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

c. Inpatient Services

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

d. Other

Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in section D., 1.

2. Durable Diabetic Equipment and Related Supplies

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

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

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

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

3. Medical Supplies and Durable Medical Equipment

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

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

- 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 pros-

thesis is not possible.

- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- Rental or, at the option of the Health Plan, purchase of equipment including, but not limited to, wheelchairs and hospital-type beds.
- An initial lens per surgical eye directly related to cataract surgery (contact lens or framed lens).
- IUDs and diaphragms.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.
- Cochlear implants, as described in the Schedule of Benefits.
- One hearing aid, as described in the Schedule of Benefits. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.
- Ostomy and catheter supplies.
- Oxygen and respiratory equipment for home use when authorized by the Health Plan.
- Other medical equipment and supplies as approved by the Health Plan. Rental or purchase of equipment/supplies is at the option of the Health Plan.
- When Prior Authorized as determined by the Health Plan, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the Health Plan will consider whether: i) the equipment/supply is still useful or has exceeded its lifetime under normal use; or ii) the Participant's condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development). Services will be covered subject to cost sharing as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual out-of-pocket limit.

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

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

a. Emergency or Urgent Care. Non-urgent follow-up care out of the Service Area must be Prior Authorized or it will not be covered; and

b. Outpatient mental health services and treatment of alcohol or drug abuse if the Dependent is a full-time student attending school in Wisconsin, but outside of the Plan Service Area, as required by Wis. Stat. 609.655. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider when Prior Authorized

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

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

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

6. **Coverage of Treatment for Autism Spectrum Disorders**

Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following Plan Providers: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those four types of providers, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. The therapy limit does not apply to this benefit.

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

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

If You do not show Your PBM identification card at the pharmacy at the time You are obtaining benefits, You may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription

name, and retail price (in U.S. currency). In these situations, You may be responsible for more than the Copayment amount. The PBM will determine the benefit amount based on the network price.

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

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

1. Prescription Drugs

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

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

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

(for example, Self-Administered Injectable).

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

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

Prescription drugs will be dispensed as follows:

a. In maximum quantities not to exceed a 30 consecutive day supply per Copayment.

b. The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

c. Single packaged items are limited to two items per Copayment or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.

d. Oral contraceptives are not subject to the 30-day supply and will be dispensed at one Copayment per package or a 28-day supply, whichever is less.

e. Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the Formulary. These require a prescription from a physician and must be filled at a Participating Pharmacy. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug Copayment and annual out-of-pocket limit. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year, unless the Participant obtains prior authorization for a limited extension.

f. Prior Authorization from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring Prior Authorization is available from the PBM.

g. Cost-effective Generic Equivalents will be dispensed unless the Plan Provider specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the Copayment specified in the Formulary.

h. Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Formulary prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two Copayments will be applied to a 90-day supply of drugs if at least a 90-day supply

is prescribed. Self-Administered Injectables and narcotics are among those for which a 90-day supply is not available.

i. Tablet splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 Formulary drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. Participants who use tablet splitting will pay half the normal Copayment amount.

j. Generic sampling is available to encourage the use of Level 1 Formulary medications, whereby the PBM may waive the Copayment of a Level 1 Formulary prescription drug on the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.

k. The PBM reserves the right to designate certain over-the-counter drugs on the Formulary.

l. Specialty Medications and Self-Administered Injectables when obtained by prescription and which can safely be administered by the Participant, must be obtained from a PBM Participating Pharmacy or in some cases, the PBM may need to limit availability to specific pharmacies.

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

2. Insulin, Disposable Diabetic Supplies, Glucometers

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

a. Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30-consecutive-day supply for one prescription drug Copayment, as described on the Schedule of Benefits.

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

3. Other Devices and Supplies

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

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

IV. EXCLUSIONS AND LIMITATIONS

A. Exclusions

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

1. Surgical Services

a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.

b. Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

c. Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

2. Medical Services

a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits and Services section.

b. Expenses for medical reports, including preparation and presentation.

c. Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; or (c) treatment of flexible flat feet. This exclusion does not apply when services are performed by a Plan Provider to treat a metabolic or peripheral disease or a skin or tissue infection.

d. Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include Nutritional Counseling as provided in the Benefits and Services section.

e. Work-related preventive

treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).

f. Services of a blood donor. Medically Necessary autologous blood donations are not considered to be Services of a blood donor.

g. Genetic testing and/or genetic counseling services, unless Medically Necessary to diagnose or treat an existing Illness.

3. Ambulance Services

a. Ambulance service, except as outlined in the Benefits and Services section, unless authorized by the Health Plan.

b. Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services section.

4. Therapies

a. Vocational rehabilitation including work hardening programs.

b. Therapies, as determined by the Health Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein. These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction. (Note: Mandated benefits for autism spectrum disorders under Wis. Stat. §632.895 (12m) limit this exclusion.)

c. Physical fitness or exercise programs.

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

e. Massage therapy.

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

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

b. All periodontic procedures, except gingivectomy surgery as listed in the Benefits and Services section.

c. All oral surgical procedures not specifically listed in the Benefits and Services section.

6. Transplants

a. Transplants and all related services, except those listed as covered procedures.

b. Services in connection with covered transplants unless Prior Authorized by the Health Plan.

c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

d. Purchase price of bone marrow, organ or tissue that is sold rather than donated.

e. All separately billed donor-related services, except for kidney transplants.

f. Non-human organ transplants or artificial organs.

7. Reproductive Services

a. Infertility services which are not for treatment of Illness or Injury (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an Illness.

b. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c. Services for storage or processing of semen (sperm); donor sperm.

d. Harvesting of eggs and their cryopreservation.

e. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related Hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

f. Surrogate mother services.

g. Maternity services received out of the Plan Service Area one month prior to the estimated due date, unless Prior Authorized (Prior Authorization will be granted only if the situation is out of the Participant's control, for example, family emergency).

h. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

8. Hospital Inpatient Services

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

b. Hospital stays, which are extended for reasons other than Medical Necessity, limited to lack of transportation, lack of

caregiver, inclement weather and other, like reasons.

c. A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, Skilled Nursing Facility.

9. Mental Health Services/Alcohol and Drug Abuse

a. Hypnotherapy.

b. Marriage counseling.

c. Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37.

d. Biofeedback.

10. Durable Medical or Diabetic Equipment and Supplies

a. All Durable Medical Equipment purchases or rentals unless Prior Authorized as required by the Health Plan.

b. Repairs and replacement of Durable Medical Equipment/ supplies unless authorized by the Health Plan.

c. Medical Supplies and Durable Medical Equipment for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices not Medically Necessary, as determined by the Health Plan, including, but not limited to, shower chairs and reaches.

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

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

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

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

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

11. Outpatient Prescription Drugs – Administered by the PBM

a. Charges for supplies and

medicines with or without a doctor's prescription, unless otherwise specifically covered.

b. Charges for prescription drugs which require Prior Authorization unless approved by the PBM.

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

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

e. Anorexic agents.

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

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

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

i. Charges for injectable medications, except for Self-Administered Injectable medications.

j. Charges for supplies and medicines purchased from a Non-Participating Pharmacy, except when Emergency or Urgent Care is required.

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

l. Infertility and fertility medications.

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

n. Charges for spilled, stolen or lost prescription drugs.

12. General

a. Any additional exclusion as described in the Schedule of Benefits.

b. Except for benefits payable under Medicare Part D, services to the extent the Participant is eligible for all other Medicare benefits, regardless of whether or not the Participant is actually enrolled in Medicare. This exclusion only applies if the Participant enrolled in Medicare coordinated coverage does not enroll in Medicare Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage.

c. Treatment, services and supplies for which the Participant: (a) has no obligation to pay or which would be furnished to a Participant without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any

voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

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

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

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

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

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

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

j. Maintenance Care.

k. Care provided to assist with activities of daily living (ADL).

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

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

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

o. Expenses incurred prior to the coverage Effective Date in the Health Plan and/or PBM, or services received after the Health Plan and/or PBM coverage or eligibility terminates. Except when a Participant's coverage terminates because of Subscriber cancellation or nonpayment of premium, benefits shall continue to the Participant if he or she is Confined as an inpatient on the coverage termination date but only until the attending physician determines that Confinement is no longer Medically Necessary; the contract maximum is reached; the end of 12 months after the date of termination; or Confinement ceases, whichever

occurs first. If the termination is a result of a Subscriber changing Health Plans during a prescribed enrollment period as determined by the Board, benefits after the Effective Date with the succeeding Health Plan will be the responsibility of the succeeding Health Plan unless the facility in which the Participant is Confined is not part of the succeeding Health Plan's network. In this instance, the liability will remain with the previous insurer.

p. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery.

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

r. Charges for any missed appointment.

s. Experimental services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the Health Plan and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be Experimental, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.

u. Services, including non-physician services, provided by Non-Plan Providers. Exceptions to this exclusion:

1) On written Referral by Plan Provider with the prior written authorization of the Health Plan.

2) Emergencies in the Service Area when the Primary Care Provider or another Plan Provider cannot be reached.

3) Emergency or Urgent Care services outside the Service Area. Non-urgent follow-up care requires Prior Authorization from the Health Plan.

v. Services of a specialist without a Plan Provider's written Referral, except in an Emergency or by written Prior Authorization of the Health Plan. Any Hospital or medical care or service not provided for in this document unless authorized by the Health Plan.

w. Coma stimulation programs.

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

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

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

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

ab. Services related to an Injury that was self-inflicted for the purpose of receiving Health Plan and/or PBM Benefits.

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

ad. Treatment, services and supplies for cosmetic or beautifying purposes, except when associated with a covered service to correct a functional impairment related to Congenital bodily disorders or conditions or when associated with covered reconstructive surgery due to an Illness or accidental Injury (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.

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

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

ag. Sexual counseling services related to infertility and sexual transformation.

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

B. Limitations

1. Copayments or Coinsurance are:

   a. State of Wisconsin program

Participants, except for retirees for whom Medicare is the primary payor, for all services unless otherwise required under federal and state law.

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

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

3. Use of Non-Plan Providers and Hospitals requires prior written approval by the Participant's Primary Care Provider and the Health Plan to determine medical appropriateness and whether services can be provided by Plan Providers.

4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.

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

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

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

8. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

V. COORDINATION OF BENEFITS AND SERVICES

A. Applicability

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

B. Definitions

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

1. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined by the Plan.
   When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.
   However, not withstanding the above, when there is a maximum benefit limitation for a specific service or treatment, the secondary plan will also be responsible for paying up to the maximum benefit allowed for its plan. This will not duplicate benefits paid by the primary plan.
2. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.
3. "Plan" means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:
   a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
   b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of

any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under a. or b. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

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

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

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

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

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

C. Order Of Benefit Determination Rules

1. General

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

a. the other Plan has rules coordinating its benefits with those of This Plan; and

b. both those rules and This Plan's rules described in subparagraph 2 require that This Plan's benefits be determined before those of the other Plan.

2. Rules

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

a. Non-Dependent/Dependent

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

b. Dependent Child/Parents Not Separated or Divorced

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

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

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

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

of benefits, the rule in the other Plan shall determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

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

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

2) then, the Plan of the spouse of the parent with the custody of the child; and

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

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

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

d. Active/Inactive Employee

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

e. Continuation Coverage

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

i. First, the benefits of a plan covering the person as an employee, member, or subscriber or as a Dependent of an employee, member, or subscriber.

ii. Second, the benefits under the continuation coverage.

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

f. Longer/Shorter Length of Coverage

If none of the above rules

determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

D. Effect On The Benefits Of The Plan

1. When This Section Applies

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

2. Reduction in This Plan's Benefits

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

a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

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

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

E. Right To Receive And Release Needed Information

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

F. Facility Of Payment

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

G. Right Of Recovery

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

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

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

VI. MISCELLANEOUS PROVISIONS

A. Right To Obtain and Provide Information

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

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

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

B. Physical Examination

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

C. Case Management/Alternate Treatment

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

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

If the Health Plan agrees to the attending physician's recommendation or if the Participant or his/her authorized representative and the attending physician agree to the Health Plan's recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the Health Plan. The PBM may establish similar case management services.

D. Disenrollment

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

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

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

In situations where a Participant has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate Primary Care Provider, disenrollment efforts may be initiated by the Health Plan or the Board. The Subscriber's disenrollment is effective the first of the month following completion of the Grievance process and approval of the Board. Coverage may be transferred to the Standard Plan only, with options to enroll in alternate Health Plans during subsequent It's Your Choice Open Enrollment periods. Reenrollment in the Health Plan is available during a regular It's Your Choice Open Enrollment period that begins a minimum of 12 months after the disenrollment date.

E. Recovery Of Excess Payments

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

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

F. Limit On Assignability Of Benefits

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

G. Severability

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

H. Subrogation

Each Participant agrees that the insurer under these Uniform Benefits, whether that is a Health Plan or the Department, shall be subrogated to a Participant's rights to damages, to the extent of the benefits the insurer provides under the policy, for Illness or Injury a third party caused or is liable for.

It is only necessary that the Illness or Injury occur through the act of a third party. The insurer's rights of full recovery may be from any source, including but not limited to:

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

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

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

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

I. Proof Of Claim

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

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

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

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

J. Grievance Process

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

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

You may also request an independent review per Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. In this event, You must notify the Health Plan and/or PBM of Your request. In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11, any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, you have no further right to administrative review once the Independent Review Organization decision is rendered.

K. Appeals To The Group Insurance Board

After exhausting the Health Plan's or PBM's Grievance process and review by the Department, the Participant may appeal the Department's determination to the Group Insurance Board, unless an Independent Review Organization decision that is final and binding has been rendered in accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of medical necessity or whether a treatment or service is Experimental. These appeals are reviewed only to determine whether the Health Plan breached its contract with the Group Insurance Board.

Note: The Quick Reference Guide is intended only to help locate the most commonly used benefits and services listed in the Uniform Benefits section of the 2013 It's Your Choice Reference Guide. It is not part of your insurance contract or a comprehensive listing of benefits, services, exclusions or limitations in your health plan. As such, it should not be relied on as a comprehensive listing of items contained within your insurance contract or the 2013 It's Your Choice Reference Guide.

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WHERE TO GET MORE INFORMATION

If you need additional information regarding:

- **Benefits**
- **Participating Providers**
- **Exclusions**
- **Limitations**

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

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

If you need additional information regarding:

- **Applications**
- **Enrollment**
- **Eligibility**
- **General Information**

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

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

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

- Additional information is available on ETF's Internet site at **etf.wi.gov**.

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

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