AGENDA AND NOTICE OF MEETING

State of Wisconsin
GROUP INSURANCE BOARD MEETING

Tuesday, June 10, 2008
9:00 a.m.

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

Times shown are estimates only.
Denotes action item.

9:00 a.m.	⬅	**1.**	**Consideration of Minutes of April 15, 2008, Meeting**

9:05 a.m.	⬅	**2.**	**Income Continuation Insurance (ICI) Program**
			• Acceptance of Actuarial Valuations
			  ➢ State Plan
			  ➢ Local Plan

9:35 a.m.		**3.**	**Update on Disability Insurance Plans** • Presentation by Aetna
10:05 a.m.	⬅	**4.**	**Health Insurance Program** • Self-Insured Health Plans Presentation by Wisconsin Physicians Service (WPS) • Technical Changes to 2009 Guidelines and Uniform Benefits • Consideration of Contract Amendments for Self-Insured Health Plans • *Alternate Plan Financial Status
10:35 a.m.		**5.**	**Announcement of Action Taken on Business Deliberated During Closed Session**
10:40 a.m.		**6.**	**Miscellaneous** • Correspondence and Complaint Summary • 2007 Health Plan and Pharmacy Benefit Manager Grievance and Independent Review Report • Employee Trust Funds 2007 Insurance Complaint Report • Legislative Update • Pending Appeals Status Report • 2008 Group Insurance Board Roster • Participant Correspondence • Future agenda items
10:45 a.m.		**7.**	**Adjournment**

* The Board may be required to meet in closed session pursuant to the exemptions contained in Wis. Stats. § 19.85(1)(e) to discuss the use of public employee trust funds. If a closed session is held, the Board will reconvene into open session for further actions on these and subsequent agenda items.

The documents for this meeting are available on-line at:

http://etf.wi.gov/boards/agendas_gib.htm

To request a printed copy of any of the above items, please contact the Board Liaison, Sharon Walk, at 608-267-2417.

The meeting location is handicap accessible. If you need other special accommodations due to a disability, please contact Sharon Walk, Department of Employee Trust Funds, PO Box 7931, Madison, WI 53707-7931. Telephone number: (608) 267-2417. TTY #: (608) 267-0676. e-mail: sharon.walk@etf.state.wi.us.

MINUTES OF MEETING

DRAFT

STATE OF WISCONSIN
GROUP INSURANCE BOARD

Tuesday, April 15, 2008

Holiday Inn
1109 Fourier Drive
Madison, Wisconsin

BOARD PRESENT: Stephen Frankel, Chair
Cindy O'Donnell, Vice-Chair
Esther Olson, Secretary
Robert Baird
Martin Beil
Jeannette Bell
Janis Doleschal
Jennifer Donnelly
Eileen Mallow
David Schmiedicke
Gary Sherman

BOARD NOT PRESENT: None

PARTICIPATING ETF STAFF: Dave Stella, Secretary
Bob Conlin, Deputy Secretary
Tom Korpady, Administrator, Division of Insurance Services
Bill Kox, Director, Health Benefits and Insurance Plans Bureau
Matt Stohr, Director of Legislation, Communications, and Planning
Sharon Walk, Group Insurance Board Liaison

OTHERS PRESENT: Michelle Baxter, Division of Trust Finance and Employer Services
Marcia Blumer, Division of Insurance Services
Jeff Bogardus, Division of Insurance Services
Penny Bound, Dean Health Plan
Liz Doss-Anderson, Division of Management Services
Jodi Dunaway, Mercy Care
Kjirsten Eisner, Minnesota Life Insurance Company
Lisa Ellinger, Division of Insurance Services
Ralph Epifanlo, Anthem Blue Cross Blue Shield
Colleen Evans-Carter, Compcare Blue
David Fee, Humana
Caitlin Frederick, Department of Administration
David Grunke, Wisconsin Physicians Service Insurance Corporation
Tim Gustafson, Deloitte Consulting LLP
Emily Halter, Group Health Cooperative South Central
Ross Hampton, Wisconsin Education Association Trust
Anja Hartmann, Dean Health Plan
Sue Hill, Navitus

Board	Mtg Date	Item #
GIB	06/10/2008	1

Steve Hurley, Division of Management Services
Kathy Ikeman, Unity Health Insurance
Char Johnson, Security Health Plan
Joy Kaiser, Medical Associates Health Plans
Christina Keeley, Division of Management Services
Sari King, Division of Retirement Services
Jon Kranz, Office of Internal Audit and Budget
Arlene Larson, Division of Insurance Services
Julie Maendel, Deloitte Consulting LLP
Ann McCarthy, Division of Management Services
Peg Narloch, Division of Insurance Services
Greg Nelson, Wisconsin Physicians Service Insurance Corporation
Paul Ostrowski, Office of State Employment Relations
Ryan Pelz, Mercy Care
Roxanne Perillo, Humana
Paul Perkins, Group Health Cooperative
Diane Poole, Division of Insurance Services
Gail Reckner, Security Health Plan
Clay Rehm, Division of Information Technology
Beth Ritchie, University of Wisconsin System Administration
Deb Roemer, Division of Insurance Services
Peter Roverud, Deloitte Consulting LLP
Chris Schmelzer, Minnesota Life Insurance Company
Ron Sebranek, Physicians Plus Insurance Corporation
Mel Sensenbrenner, State Engineers Association
Chris Setter, Anthem Blue Cross Blue Shield
Sonya Sidky, Division of Insurance Services
Joan Steele, Division of Insurance Services
John Verberkmoes, American Federation of Teachers-Wisconsin
John Vincent, Division of Trust Finance and Employer Services
Brandon Widell, United Health Care
Art Zimmerman, Legislative Fiscal Bureau

Stephen Frankel, Chair, Group Insurance Board (Board), called the meeting to order at 8:34 a.m.

ANNOUNCEMENTS

Mr. Korpady introduced Lisa Ellinger, the new Deputy Administrator in the Division of Insurance Services. He also recognized retiring Board member Jeannette Bell. He thanked Ms. Bell for her service on the Board and wished her well in her retirement.

CONSIDERATION OF MINUTES OF FEBRUARY 12, 2008, MEETING

MOTION: Ms. Mallow moved approval of the open and closed session minutes of the February 12, 2008, meeting as submitted by the Board Liaison. Ms. Olson seconded the motion, which passed without objection on a voice vote.

HEALTH INSURANCE PROGRAM

Dual-Choice Enrollment Dates. Mr. Korpady asked for the Board's approval to establish the Dual-Choice enrollment period from October 6-24, 2008, for coverage effective on January 1, 2009.

MOTION: Mr. Beil moved to establish October 6-24, 2008, as the Dual-Choice Enrollment dates. Ms. Olson seconded the motion, which passed on the following voice vote:

Members Voting Aye: Baird, Beil, Bell, Doleschal, Donnelly, Frankel, Mallow, O'Donnell, Olson, and Schmiedicke.

Members Voting Nay: Sherman.

2009 Guidelines and Uniform Benefits. Mr. Kox discussed the Guidelines and Uniform Benefits for the 2009 benefit year. As in past years, a study group met to discuss recommendations for changes to the health insurance contract and the Uniform Benefits package. The study group included representatives from the Office of the Commissioner of Insurance, Department of Administration and the Office of State Employment Relations along with the Department of Employee Trust Funds (Department). A comprehensive memorandum describing the proposed changes and clarifications was presented to the Board for review. Mr. Kox discussed the attachments to the memo. He recommended that the Board adopt the changes discussed in the memo and grant Department staff the authority to make any additional technical changes as necessary.

Recommended Changes to the Guidelines and State and Local Contracts. Mr. Kox discussed the following recommended changes to the state and local contracts.

State Maintenance Plan: The study group recommended giving the Board the flexibility to make the State Maintenance Plan available as a Tier 2 plan in any county, whether or not a qualified Tier 1 plan is available. This may be used to supplement provider availability in areas where the Standard Plan is the only other alternative.

Incorporation of Pharmacy Data: The study group recommended expanding the requirement for health plans to incorporate the Department's pharmacy claims data into all aspects of disease management. Currently, health plans are only required by contract to incorporate the pharmacy claims data into the Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Annual Utilization Report: The study group recommended requiring health plans to submit an annual utilization report describing utilization trends in the state and local programs, and how these trends compare to the health plan's commercial business.

Recommended Changes To The Local Contract.

Underwriting: Currently, the Board has an underwriting process for large employers with 51 or more eligible employees. The study group recommended expanding the underwriting process to small employers with 50 or fewer eligible employees. Surcharges for higher risk groups would likely be higher and could range up to 85%.

Employers would be assessed a fee to cover the cost of the underwriting process. The details relating to this process are being discussed by staff. Prior to implementation, the Department will make a report to the Board.

Opt-Out Surcharge: To protect the program from adverse selection caused by opt-out provisions in local employer labor agreements, the study group recommended that language be added to the health insurance contract that would allow the Board to assess a surcharge, as determined by the Board's actuary, when a local employer does not remove a provision that provides financial incentives for employees to opt out of our group health coverage.

Recommended Change To Uniform Benefits

Cost-neutral recommendation: Mr. Kox discussed the Pharmacy Annual Out-of-Pocket (OOP) Maximum. The annual OOP maximum is currently $350 per individual/$700 per family. The study group recommended increasing the OOP maximum to $385/$770 for 2009.

Recommendations affecting costs: Mr. Kox discussed enteral (tube) feedings and emergency room copayments. The study group was not able to reach a consensus on recommending inclusion of enteral feedings and increasing emergency room copayments to offset the cost, and decided to bring the issues to the Board for discussion.

Discussion of Other Issues

There were other issues considered by the study group that resulted in no recommended changes. These issues included:

1. Review of provider qualification criteria;
2. Minimum dental benefit level;
3. Medicare as primary payer for local employers;
4. High-deductible option for local employers;
5. Non-payment for medical errors;
6. Maintenance therapy;
7. Hearing aid benefit;
8. Biofeedback;
9. Contact lens fittings;
10. Imaging copayment; and
11. Pharmacy copayments.

In response to questions from Mr. Beil, Mr. Kox noted that the study group had looked at gastric bypass surgery. Mr. Roverud from Deloitte Consulting indicated that costs continue to rise due to increases in utilization.

MOTION: Ms. Mallow moved that the Board accept the recommendations with respect to changes to the Guidelines and State and Local Contracts. Ms. Olson seconded the motion, which passed without objection on a voice vote.

MOTION: Ms. Olson moved to accept the recommendation with respect to underwriting changes and an opt-out surcharge in the Local Contract. Mr. Beil seconded the motion, which passed without objection on a voice vote.

MOTION: Ms. Doleschal moved to accept the recommendation to increase the out-of-pocket maximum from $350 to $385 per individual and from $700 to $770 per family. Ms. Bell seconded the motion, which passed without objection on a voice vote.

Health Risk Assessment Tools.

Mr. Korpady discussed the memo in the Board packet regarding Health Risk Assessments (HRA). The Department surveyed the health insurance plans and compiled basic information about HRA options currently available. Mr. Korpady noted that this topic will continue to be discussed with the Board and the health plans.

LEGISLATIVE UPDATE

Mr. Stohr updated the Board on the 2007-2008 legislative session, noting that the general legislative session concluded on March 13, 2008. Mr. Stohr discussed Assembly Bill (AB) 893, a technical bill, which was signed into law as Act 131. This act conforms state law with current practices and with federal law, creates efficiencies in the operations of Department programs and eliminates several inequities with previous laws.

Mr. Stohr also discussed AB 668 and its companion bill, Senate Bill (SB) 336. These bills would have expanded the membership of the Group Insurance Board from six appointed persons to eight appointed members, one from each of the eight different congressional districts. The bills were not signed into law but it is possible that they will be reintroduced in the next legislative session.

MISCELLANEOUS

Mr. Korpady referred the Board members to the miscellaneous items included in the Board packets.

MOTION TO CONVENE IN CLOSED SESSION

Mr. Frankel announced that the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85(1)(e) for the purpose of discussing the use of public employee trust funds. Staff from the Department of Employee Trust Funds, the Department of Administration, and the Office of State Employment Relations were invited to remain during the closed session.

MOTION: Mr. Beil moved to convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1)(e) for the purpose of discussing the use of public employee trust funds. Mr. Baird seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Baird, Beil, Bell, Doleschal, Donnelly, Frankel, Mallow, O'Donnell, Olson, Schmiedicke, and Sherman

Members Voting Nay: None

The Board convened in closed session at 10:15 a.m. and reconvened in open session at 10:50 a.m.

Mr. Frankel announced that the Board took the following action during the closed session:

INCOME CONTINUATION INSURANCE (ICI) AND LONG-TERM DISABILITY INSURANCE (LTDI) PROGRAMS

Mr. Frankel announced that the Board accepted the proposal submitted by Aetna for the administration of the ICI and LTDI plans pending successful negotiations with Aetna to clarify terms, conditions, reporting requirements and administrative costs.

LIFE INSURANCE CONTRACT EXTENSION

Mr. Frankel announced that the Board approved extending the contract with Minnesota Life Insurance Company for two years from January 1, 2009, through December 31, 2010.

ADJOURNMENT

MOTION: Mr. Sherman moved adjournment. Mr. Beil seconded the motion, which passed without objection on a voice vote.

The Board adjourned at 10:52 a.m.

Dated Approved: _____

Signed: _____
Esther Olson, Secretary
Group Insurance Board

Deloitte.

The State of Wisconsin

State Income Continuation Insurance Plan Actuarial Review as of December 31, 2007

Audit . Tax . Consulting . Financial Advisory.

Prepared By:
Timothy D. Gustafson, FSA, MAAA
Deloitte Consulting LLP

Table of Contents

I. Overview

The purpose of this report is to summarize our review of the State Income Continuation Insurance Plan. Included are a brief review of the Plan's experience during 2007, an estimate of the State's liability as of December 31, 2007, and an analysis of current funding levels.

In preparing this report, we have relied on claim information provided by Aetna and the Department of Employee Trust Funds. We have not audited this information, but have relied on it as submitted after making reasonableness checks and corrections as we deemed appropriate under the circumstances.

The results of this review indicate that the State Income Continuation Insurance Plan (including supplemental benefits) has assets of $62.0 million and estimated liabilities of $64.8 million as of December 31, 2007. The asset balance does not include $13.8 million in deferred market gains which will be smoothed in over the next four years. The net fund balance is $(2.8) million. This net fund balance represents approximately (4.3)% of liabilities. Traditionally, a long-term objective of maintaining a net fund balance of 15% to 25% of estimated liabilities has been considered reasonable.

Premiums were reinstated for this plan on August 1, 1996. These premiums stabilized the funded status of the plan for a number of years. The annual net fund balances (as a percentage of liabilities) were 15% in 2001, 13% in 2002, 17% in 2003, 10% in 2004, (1.5)% in 2005 and (9.4)% in 2006. Throughout the course of 2005 and 2006, the funded status of the plan deteriorated and is no longer in the targeted range. The funded status of the plan is (4.3)% at the end of 2007. An increase in premium revenue of approximately 7% took effect February 1, 2007. While the net fund balance remains in a deficit position, the early affects of the increase in premium can be seen in the 5.1% increase of the net fund proportion of total liabilities. As the increased premium level had only been in effect for 11 months at the time of the valuation, further impacts of the new premium level are expected to be evident in future valuations.

The remainder of this report summarizes the review in more detail. A number of assumptions have been made in estimating the State's liability, which are described throughout the report and summarized in Exhibit 1.

II. 2007 Experience Review

Fund Balance

During 2007, the fund balance increased from $60,722,872 to $62,022,782; investment earnings were $7,011,277 with paid claims and administrative expenses totaling $17,094,666. As shown below, there was a positive cash flow in 2007, which is driven by the 7% premium increase which took effect February 1, 2007, as well as higher rates of recognized investment earnings. These components are shown in the following table along with figures for the previous three years for comparison purposes.

	2007	2006	2005	2004
Beginning Balance	60,722,872	62,548,480	64,107,888	64,035,892
Closing Adjustments	(47,211)	22,594	(18,654)	(190,862)
Adjusted Beginning Balance	**60,675,661**	**62,571,074**	**64,089,234**	**63,845,030**
Revenues				
Contributions	11,430,510	9,961,219	9,777,198	9,621,923
Investment Earnings	7,011,277	5,812,959	3,986,175	5,090,324
Total	**18,441,787**	**15,774,178**	**13,763,373**	**14,712,247**
Expenses				
Paid Claims	14,875,149	15,345,079	13,341,722	12,453,660
Administrative Expenses	2,219,517	2,277,300	1,962,404	1,995,729
Total	**17,094,666**	**17,622,379**	**15,304,126**	**14,449,389**
Net Income	**1,347,121**	**(1,848,201)**	**(1,540,754)**	**262,858**
Ending Balance	**62,022,782**	**60,722,872**	**62,548,480**	**64,107,888**
Investment Earnings/Mean Balance	**12.1%**	**9.9%**	**6.5%**	**8.3%**

As of December 31, 2007 there were 1,064 open claims. During 2007, 1,412 claims were closed. Total reported claims incurred during 2007 were 2,476. The following table shows the number of open and closed claims by year incurred and the average net monthly benefit.

Claims by Year of Incurral

	Open Claims		Closed Claims		All Claims	
Year Incurred	Number	Average Benefit	Number	Average Benefit	Number	Average Benefit
2007	308	$ 1,845	689	$ 1,071	997	$ 1,310
2006	116	1,135	588	897	704	936
2005	114	1,108	54	904	168	1,042
2004	103	843	31	697	134	809
2003	63	641	11	865	74	675
2002	55	721	8	496	63	692
2001	36	604	7	534	43	592
2000	34	696	3	502	37	680
1999	28	791	2	1,524	30	840
1998	27	671	2	12,863	29	1,512
1997	21	553	4	483	25	542
1996	29	756	1	1,843	30	792
1995	23	612	2	504	25	604
1994	25	577	0	-	25	577
1993	11	531	3	362	14	495
1992	11	727	0	-	11	727
1991	12	1,156	0	-	12	1,156
1990	12	627	1	456	13	614
1989 & Prior	36	683	6	414	42	645
Total	**1,064**	**$ 1,128**	**1,412**	**$ 997**	**2,476**	**$ 1,065**

The number of open claims for 2007 decreased compared to last year, while the average benefit amount increased slightly for these open claims. Both the count of closed claims and their average benefit increased in 2007. The following table shows this comparison for the last few years.

Claims by Valuation Date

	Open Claims		Closed Claims		All Claims	
Valuation Year	Number	Average Benefit	Number	Average Benefit	Number	Average Benefit
2007	1,064	$ 1,128	1,412	$ 997	2,476	$ 1,065
2006	1,123	1,146	1,295	881	2,418	1,004
2005	1,054	1,211	1,215	1,009	2,269	1,103
2004	972	1,168	1,205	1,042	2,177	1,098
2003	876	1,255	1,148	1,261	2,024	1,258
2002	895	1,042	1,086	1,012	1,981	1,025
2001	1,084	1,132	662	2,044	1,746	1,478
2000	809	1,078	1,246	1,465	2,055	1,313
1999	757	998	1,323	1,381	2,080	1,242
1998	855	1,040	1,501	1,339	2,356	1,231
1997	859	1,004	1,068	1,364	1,927	1,203
1996	839	1,036	1,283	1,281	2,122	1,184
1995	872	933	1,094	1,309	1,966	1,142

III. Estimated Liability as of December 31, 2007

The State's liability for outstanding claims under the State Income Continuation Insurance Plan was estimated in two parts — reported claims and incurred but unreported claims. The following paragraphs summarize the method used and results.

Reported Claims

Disabled life reserve factors were calculated using the 1987 Commissioner's Group Basic Disability table adjusted for the State's own termination experience. These factors represent the present value of future payments, at 7.8% interest, to a disabled person with a monthly benefit of $100. The WRS valuation rate was reduced from 8.0% to 7.8% as of February 1, 2004 and has remained at 7.8% since. For consistency and per the direction of ETF personnel, the valuation interest rate is tied to the WRS valuation rate; therefore a 7.8% discount rate was used for the December 31, 2007 valuation. The factors are indexed by age at disablement, duration of disablement, and duration to the end of the benefit period.

Aetna provided a listing of those persons known to be disabled as of December 31, 2007. The age at disablement, duration of disability, and duration to the end of the benefit period was calculated for each individual. The appropriate factors were then multiplied by the amount of benefit for each disabled person. The results were summarized by year incurred and in total.

For disabilities that last over one year, a supplement of $75 per month is included in the normal benefit amount for the purpose of defraying medical costs. A liability was added for those claims incurring in 2007 representing the probability that claims will continue beyond the first year and the present value of the additional benefit. The liability for the $75 supplement is already included in the liability for claims over one year.

Incurred But Unreported Claims

In addition to those claims reported as of December 31st, there presumably are other claims incurred prior to that date but which are not as yet reported. The State's liability for long-term disability claims begins on the date an employee is disabled, even though the employee is not eligible for payments during the waiting period or has not yet filed a claim. Thus, it is necessary to estimate the additional liability for claims incurred but not reported as of the valuation date.

Besides the waiting period, delays in the reporting and processing of claims normally occur. From the State's own experience, we observed that approximately 25% of claims open and closed during the previous twelve months are unreported as of year end. Thus, the State's liability for claims incurred but not yet reported was calculated as the estimated number of incurred but not yet reported claims times an average benefit amount times an average disabled life reserve factor. This methodology has produced stable results over the past several years.

Results

The total estimated liability as of December 31, 2007 for the State Income Continuation Insurance Plan is $64,830,406, developed as follows:

Reported Claim Liability	$55,715,554
$75 Supplement	489,025
Total Reported Liability	$56,204,579
Incurred But Not Reported Liability	8,625,827
Total Liability	$64,830,406

This total liability is 3.3% lower than the liability determined as of December 31, 2006 due to the combined effect of a decrease in the open claims and a decrease in the average net benefit.

Exhibit 2 contains a breakdown of the $56,204,579 reported liability by year of disability.

IV. Analysis of Funding Levels

The State Income Continuation Insurance Plan has assets of $62.7 million and estimated liabilities of $64.8 million, producing a net fund balance of $(2.8) million. Investment earnings covered 41% of paid claims and administrative expenses. The premiums cover 67% of paid claims and administrative expenses. Premiums plus investment earnings combined covered the entirety of paid claims and administrative expenses. Thus, cash flow in the trust was positive this year. Cumulative cash flows for plan years 2002 through 2007 are ($501,080).

Considerable year-to-year fluctuations can occur under disability income plans, even for a plan as large as that of the State. Thus, it is prudent to maintain a fund balance in excess of estimated liabilities. A reasonable long-term objective has been to maintain a net fund balance of 15% to 25% of estimated liabilities as a hedge against future adverse experience. The current total fund balance is 96.8% of liabilities (as compared to 90.6% last year). The net fund balance is not in the targeted range for the second consecutive year. As part of the December 31, 2005 valuation, Deloitte recommended a 7% increase in premium revenue, which took effect February 1, 2007. However the premium increase did not fully impact the December 31, 2007 valuation, as it had only been in effect for eleven months.

Also, there is currently in excess of $13.8 million of deferred investment gains which will be gradually smoothed into the fund by 2011. Hence we recommend that the plan's experience be monitored for 1 to 2 years before another premium increase is considered.

Exhibit 1

Elimination Period — 90 days average. Actual waiting period varies with accumulated sick leave and for University faculty, the elimination period selected.

Benefit Period — The maximum duration of benefits for disabled insured employees is:

Age at Disablement	Maximum Duration of Benefits in Years
61 or Younger	To age 65
62	3.50 years
63	3.00 years
64	2.50 years
65	2.00 years
66	1.75 years
67	1.50 years
68	1.25 years
69	1.00 years

In no event are benefits payable beyond the 70th birthday.

Termination Rates — Percentage of the 1987 Commissioner's Basic Disability Table three month elimination period termination rates based on the State's own experience, as shown below:

Duration of Disablement	Termination Rate Adjustment
First Year	280%
Second Year	260%
Third Year	240%
Fourth Year	220%
Fifth Year	200%
Sixth Year	180%
Seventh Year	160%
Eighth Year	140%
Ninth Year	120%
Tenth Year & Later	100%

Interest — 7.8% per year.

Contingency Margins — None.

Exhibit 2

Reported Claim Liability by Year of Disability

Open Claims as of December 31, 2007						
Year of Disability	**Number**	**Gross Benefit**	**Offset Amount**	**Net Benefit**	**$75 Supplement**	**Estimated Liability**
2007	308	$ 645,040	$ 76,725	$ 568,315	$ 489,025	$ 15,010,725
2006	116	269,456	137,840	131,616	-	7,149,827
2005	114	264,699	138,379	126,321	-	8,006,650
2004	103	226,538	139,688	86,850	-	6,285,479
2003	63	140,397	99,991	40,406	-	2,916,775
2002	55	120,630	80,993	39,637	-	2,564,498
2001	36	71,378	49,640	21,738	-	1,817,272
2000	34	66,556	42,902	23,653	-	1,894,342
1999	28	63,158	41,009	22,149	-	1,760,475
1998	27	59,766	41,647	18,119	-	1,162,078
1997	21	41,087	29,465	11,622	-	678,554
1996	29	53,429	31,518	21,911	-	1,421,589
1995	23	42,097	28,012	14,085	-	805,927
1994	25	40,815	26,402	14,413	-	880,665
1993	11	15,543	9,700	5,843	-	434,288
1992	11	16,988	8,992	7,996	-	553,409
1991	12	19,765	5,892	13,874	-	1,024,808
1990	12	19,036	11,514	7,522	-	400,341
1989	11	14,647	7,059	7,588	-	392,673
1988	7	11,479	4,152	7,327	-	528,659
1987	6	7,580	3,741	3,839	-	137,602
1986	2	2,049	1,415	634	-	45,149
1984	3	2,992	1,579	1,413	-	95,003
1983	2	2,153	431	1,722	-	135,984
1982	1	825	416	409	-	38,225
1980	1	727	308	419	-	31,002
1979	2	1,764	997	767	-	32,580
1972	1	474	-	474	-	-
Total	**1,064**	**$ 2,221,069**	**$ 1,020,407**	**$ 1,200,662**	**$ 489,025**	**$ 56,204,579**

Deloitte Consulting LLP
111 S Wacker Dr
Chicago, IL 60606
United States

Tel: 312 486 2265
Fax: 312 486 2265
www.deloitte.com

About Deloitte

Deloitte refers to one or more of Deloitte Touche Tohmatsu, a Swiss Verein, its member firms and their respective subsidiaries and affiliates. Deloitte Touche Tohmatsu is an organization of member firms around the world devoted to excellence in providing professional services and advice, focused on client service through a global strategy executed locally in nearly 140 countries. With access to the deep intellectual capital of approximately 135,000 people worldwide, Deloitte delivers services in four professional areas, audit, tax, consulting and financial advisory services, and serves more than 80 percent of the world's largest companies, as well as large national enterprises, public institutions, locally important clients, and successful, fast-growing global growth companies. Services are not provided by the Deloitte Touche Tohmatsu Verein and, for regulatory and other reasons, certain member firms do not provide services in all four professional areas.

As a Swiss Verein (association), neither Deloitte Touche Tohmatsu nor any of its member firms has any liability for each other's acts or omissions. Each of the member firms is a separate and independent legal entity operating under the names "Deloitte", "Deloitte & Touche", "Deloitte Touche Tohmatsu" or other related names.

In the United States, Deloitte & Touche USA LLP is the U.S. member firm of Deloitte Touche Tohmatsu and services are provided by the subsidiaries of Deloitte & Touche USA LLP (Deloitte & Touche LLP, Deloitte Consulting LLP, Deloitte Financial Advisory Services LLP, Deloitte Tax LLP, and their subsidiaries), and not by Deloitte & Touche USA LLP. The subsidiaries of the U.S. member firm are among the nation's leading professional services firms, providing audit, tax, consulting, and financial advisory services through nearly 40,000 people in more than 90 cities. Known as employers of choice for innovative human resources programs, they are dedicated to helping their clients and their people excel. For more information, please visit the U.S. member firm's Web site at www.deloitte.com

Member of
Deloitte Touche Tohmatsu

Deloitte.

The State of Wisconsin

Local Income Continuation Insurance Plan Actuarial Review as of December 31, 2007

Audit . Tax . Consulting . Financial Advisory .

Prepared By:
Timothy D. Gustafson, FSA, MAAA
Deloitte Consulting LLP

Table of Contents

I. Overview

The purpose of this report is to summarize our review of the Local Income Continuation Insurance Plan. Included are a brief review of the Plan's experience during 2007, an estimate of the Plan's liability as of December 31, 2007, and an analysis of current funding levels.

In preparing this report, we have relied on claim information provided by Aetna and the Department of Employee Trust Funds. We have not audited this information, but have relied on it as submitted after making reasonableness checks as we deemed appropriate under the circumstances.

The results of this review indicate that the Local Income Continuation Insurance Plan (including supplemental benefits) is in a strong financial position, with assets of $24,150,025 and estimated liabilities of $3,822,315. The asset balance does not include $0.2 million in deferred market gains which will be smoothed over the next five years. The large net fund balance is due to a valuation methodology change, which took place at December 31, 1996.

We do not recommend a change in premium rate at this time.

The remainder of this report summarizes the review in more detail. A number of assumptions have been made in estimating the Plan's liability. These assumptions are described throughout the report and summarized in Exhibit 1.

II. 2007 Experience Review

Fund Balance

During 2007, the fund balance increased from $20,919,663 to $24,150,025; Investment earnings were $2,644,345 with paid claims and administrative expenses totaling $990,872. These components are shown in the following table along with figures for the previous three years for comparison purposes.

	2007	2006	2005	2004
Beginning Balance	20,919,663	18,604,406	16,708,151	14,715,244
Closing Adjustments	(25,656)	(125,560)	(3,488)	(30,398)
Adjusted Beginning Balance	**20,894,007**	**18,478,846**	**16,704,664**	**14,684,846**
Revenues				
Contributions	1,602,545	1,504,430	1,397,588	1,302,270
Investment Earnings	2,644,345	1,857,528	1,111,424	1,219,586
Total	**4,246,890**	**3,361,958**	**2,509,011**	**2,521,856**
Expenses				
Paid Claims	828,881	760,539	487,853	385,169
Administrative Expenses	161,991	160,602	121,416	113,381
Total	**990,872**	**921,141**	**609,269**	**498,550**
Net Income	**3,256,018**	**2,440,817**	**1,899,743**	**2,023,305**
Ending Balance	**24,150,025**	**20,919,663**	**18,604,406**	**16,708,151**
Investment Earnings/Mean Balance	**12.5%**	**9.9%**	**6.5%**	**8.1%**

The following table shows the number of open and closed claims by year incurred and the average net monthly benefit.

Claims By Year of Incurral

	Open Claims		Closed Claims		All Claims	
Year Incurred	Number	Average Benefit	Number	Average Benefit	Number	Average Benefit
2007	12	$ 1,996	39	$ 955	51	$ 1,200
2006	6	1,080	44	820	50	851
2005	11	1,198	5	1,203	16	1,200
2004	7	617	2	19	9	484
2003	5	1,292	1	909	6	1,228
2002	2	1,014	1	240	3	756
2001	2	91	1	604	3	262
2000	3	403	0	-	3	403
1999	0	-	0	-	0	-
1998	0	-	0	-	0	-
1997	1	992	1	238	2	615
1996	1	163	0	-	1	163
1995	0	-	0	-	0	-
1994	0	-	0	-	0	-
1993	1	389	0	-	1	389
Total	**51**	**$ 1,164**	**94**	**$ 866**	**145**	**$ 971**

The information for the group of participants is presented in the following table for December 31, 2007. While the data from years 1995 and prior are not necessarily directly comparable, the corresponding information for these years is presented here for illustration.

Claims By Valuation Date

	Open Claims		Closed Claims		All Claims	
Plan Year	Number	Average Benefit	Number	Average Benefit	Number	Average Benefit
2007	51	$ 1,164	94	$ 866	145	$ 971
2006	62	1,183	62	1,170	124	1,176
2005	52	1,376	49	1,195	101	1,288
2004	37	1,368	47	1,798	84	1,609
2003	27	1,276	48	1,746	75	1,577
2002	34	1,569	46	1,299	80	1,414
2001	33	1,643	14	1,479	47	1,594
2000	24	1,326	60	1,256	84	1,276
1999	21	919	43	1,041	64	1,001
1998	27	1,147	54	888	81	974
1997	24	923	36	1,118	60	1,040
1996	20	719	44	1,144	64	1,011
1995*	72	734	40	922	112	801
1994*	55	682	30	904	85	760
1993*	25	697	10	1,224	35	848

* While performing the valuation for December 31, 1996, it was determined that the criteria for including claimants in the Local Income Continuation Plan used for prior valuations was not correct. After reviewing the criteria used in prior valuations and after discussions with United Wisconsin Group, it was determined that participants from the Long-Term Disability Insurance Plan had probably been included in the valuation.

III. Estimated Liability as of December 31, 2007

The Plan's liability for outstanding claims under the Local Income Continuation Insurance program was estimated in two parts — reported claims and incurred but unreported claims. The following paragraphs summarize the method used and results.

Reported Claims

Disabled life reserve factors were calculated using the 1987 Commissioner's Group Basic Disability table adjusted for the State's own termination experience. These factors represent the present value of future payments, at 7.8% interest, to a disabled person with a monthly benefit of $100. The WRS valuation interest rate was reduced from 8% to 7.8% as of February 1, 2004 and has remained at 7.8%. For consistency, and at the direction of ETF personnel, the valuation interest rate is tied to the WRS valuation rate; therefore a 7.8% discount rate was used in the December 31, 2007 valuation. The factors are indexed by age at disablement, duration of disablement, and duration to the end of the benefit period.

Aetna provided a listing of those persons known to be disabled as of December 31, 2007. The age at disablement, duration of disability, and duration to the end of the benefit period was calculated for each individual. The appropriate factors were then multiplied by the amount of benefit for each disabled person. The results were summarized by year incurred and in total.

For disabilities that last over one year, a supplement of $75 per month is included in the normal benefit amount for the purpose of defraying medical costs. This benefit was effective January 1, 2002 for all claims in pay status.

Incurred But Unreported Claims

In addition to those claims reported as of December 31, 2007, there presumably are other claims incurred prior to that date but which are not yet reported. The Plan's liability for long-term disability claims begins on the date an employee is disabled, even though the employee is not eligible for payments during the waiting period or has not yet filed a claim. Thus, it is necessary to estimate the additional liability for claims incurred but not reported as of the valuation date.

Besides the waiting period, delays in the reporting and processing of claims normally occur. From the State's experience, we observed that approximately 25% of claims incurred during any twelve month period are unreported as of the end of that twelve month period. Thus, the Plan's liability for claims incurred but not yet reported was calculated as the estimated number of incurred but not yet reported claims times an average liability for reported claims.

Results

The total estimated liability as of December 31, 2007 for the Local Income Continuation Insurance program is $3,822,315, developed as follows:

Reported Claim Liability	$3,161,855
$75 Supplement	21,710
Total Reported Liability	3,183,565
Incurred But Not Reported Liability	638,750
Total Liability	$3,822,315

This total liability is 11% lower than the liability determined as of December 31, 2006. The decrease is the result of a decrease in open claims during the year coupled with a decrease in the average benefit.

Exhibit 2 contains a breakdown of the $3,183,565 reported liability by year of disability.

IV. Analysis of Funding Levels

The Local Income Continuation Insurance Plan continues to be in a strong financial position with assets of $24,150,025 and estimated liabilities of $3,822,315 which produces a net fund balance of $20,327,710.

A reasonable long-term objective would be to maintain a net fund balance of more than 100% of the estimated liabilities as a hedge against future adverse experience. Substantial year-to-year fluctuations can occur under disability income programs, particularly for the relatively small size of this program. Thus, in the near term, it is prudent to maintain a large fund balance in excess of estimated liabilities — perhaps 200%. The excess now represents 532% of the estimated liabilities. The following table shows the net fund balance as a percentage of the estimated liability by year. It is clear that this excess fluctuates from year to year.

	2007	2006	2005	2004	2003	2002
Assests	24,150,025	20,919,663	18,604,406	16,708,151	14,715,244	13,087,280
Estimated Liability	3,822,315	4,307,964	3,669,243	2,584,522	2,295,121	2,612,916
Net Fund Balance	20,327,710	16,611,699	14,935,163	14,123,629	12,420,123	10,474,364
Percentage	532%	386%	407%	546%	541%	401%

The employer's premium contribution rate was reduced from .375% of covered payroll to .25% effective March 1, 2002. A $75 Supplemental Add-on benefit was also added effective January 1, 2002. We will continue to monitor the experience under the revised plan. We do not recommend additional benefit or premium rate changes at this time.

Exhibit 1

Elimination Period — 90 days average. Actual waiting period can vary between 30 and 180 days.

Benefit Period — The maximum duration of benefits for disabled insured employees is:

Age at Disablement	Maximum Duration of Benefits in Years
61 or Younger	To age 65
62	3.50 years
63	3.00 years
64	2.50 years
65	2.00 years
66	1.75 years
67	1.50 years
68	1.25 years
69	1.00 years

In no event are benefits payable beyond the 70th birthday.

Termination Rates — Percentage of the 1987 Commissioner's Basic Disability Table three month elimination period termination rates based on the State's own experience, as shown below:

Duration of Disablement	Termination Rate Adjustment
First Year	280%
Second Year	260%
Third Year	240%
Fourth Year	220%
Fifth Year	200%
Sixth Year	180%
Seventh Year	160%
Eighth Year	140%
Ninth Year	120%
Tenth Year & Later	100%

Interest — 7.8% per year.

Contingency Margins — None.

Exhibit 2

Reported Claim Liability by Year of Disability

Open Claims as of December 31, 2007								
Year of Disability	Number	Gross Benefit	Offset Amount	Net Benefit	Estimated Liability	$75 Supplement	Average Benefit	Estimated Liability
2007	12	$ 26,272	$ 2,323	$ 23,949	$ 676,406	$ 21,710	$ 1,996	$ 698,116
2006	6	14,109	7,627	6,483	296,722	0	1,080	296,722
2005	11	29,355	16,178	13,177	927,326	0	1,198	927,326
2004	7	16,144	11,825	4,319	362,329	0	617	362,329
2003	5	15,960	9,499	6,461	499,996	0	1,292	499,996
2002	2	3,150	1,121	2,029	160,486	0	1,014	160,486
2001	2	3,338	3,156	181	1,797	0	91	1,797
2000	3	7,238	6,029	1,208	110,816	0	403	110,816
1997	1	1,942	950	992	105,592	0	992	105,592
1996	1	525	362	163	7,806	0	163	7,806
1993	1	833	444	389	12,579	0	389	12,579
Total	**51**	**$ 118,866**	**$ 59,514**	**$ 59,351**	**$3,161,855**	**$ 21,710**	**$ 1,164**	**$3,183,565**

Deloitte Consulting LLP
111 S Wacker Dr
Chicago, IL 60606
United States

Tel: 312 486 2265
Fax: 312 486 2265
www.deloitte.com

About Deloitte

Deloitte refers to one or more of Deloitte Touche Tohmatsu, a Swiss Verein, its member firms and their respective subsidiaries and affiliates. Deloitte Touche Tohmatsu is an organization of member firms around the world devoted to excellence in providing professional services and advice, focused on client service through a global strategy executed locally in nearly 140 countries. With access to the deep intellectual capital of approximately 135,000 people worldwide, Deloitte delivers services in four professional areas, audit, tax, consulting and financial advisory services, and serves more than 80 percent of the world's largest companies, as well as large national enterprises, public institutions, locally important clients, and successful, fast-growing global growth companies. Services are not provided by the Deloitte Touche Tohmatsu Verein and, for regulatory and other reasons, certain member firms do not provide services in all four professional areas.

As a Swiss Verein (association), neither Deloitte Touche Tohmatsu nor any of its member firms has any liability for each other's acts or omissions. Each of the member firms is a separate and independent legal entity operating under the names "Deloitte", "Deloitte & Touche", "Deloitte Touche Tohmatsu" or other related names.

In the United States, Deloitte & Touche USA LLP is the U.S. member firm of Deloitte Touche Tohmatsu and services are provided by the subsidiaries of Deloitte & Touche USA LLP (Deloitte & Touche LLP, Deloitte Consulting LLP, Deloitte Financial Advisory Services LLP, Deloitte Tax LLP, and their subsidiaries), and not by Deloitte & Touche USA LLP. The subsidiaries of the U.S. member firm are among the nation's leading professional services firms, providing audit, tax, consulting, and financial advisory services through nearly 40,000 people in more than 90 cities. Known as employers of choice for innovative human resources programs, they are dedicated to helping their clients and their people excel. For more information, please visit the U.S. member firm's Web site at www.deloitte.com

Member of
Deloitte Touche Tohmatsu

Group Insurance Board

2007 ICI and LTDI Program

June 10, 2008

We want you to know®

Agenda

- Projects and Approaches in 2007
- Executive Summary
- Performance
  - Customer Service
  - Administration
  - Claims Experience Overview
- Questions and Answers

2007 Projects/Approaches

- Continue to execute ETF Program within Aetna Claim Owner model
  - Without service interruption
- Preserve and build upon gains made post Aetna acquisition:
  - Strength and experience of ETF/Aetna staff-
    - Keep key staff on team and at Aetna
  - Strengthen team with high performers
  - Maintain vital aspects of ETF program
    - while accessing best technology and best approaches available in the industry
- Aetna Ombudsperson Activity
  - Low level - less than one incident per month
  - Usually educational in nature
- Continue to Partner with ETF team
  - Adjustments, Program Evolution, Shared Expertise
- Customer Service Focus Remains Priority
  - Improve on Customer Service Surveys from 2006

Executive Summary

- **Ombudsperson activity is down to negligible levels**
  - **Experienced staff has led to less escalation and more resolution within general process of response**
- **Key Customer Service Measures**
  - **Exceeded Customer Service Survey levels after missing this measure last year**
- **Claims Study- State ICI, Local ICI, LTDI**
  - **State ICI Program is 82% of all claims volume**
    - **Analysis will be deepest in ICI State – best insights of**
      - **Diagnostic drivers, Cost, Absence and Corresponding illness and costs on the healthcare side**
    - **Females file more claims (common in the industry)**
      - **Driven by maternity within STD**
  - **Musculoskeletal is the most common diagnostic category in all claims categories**
  - **Mental Health claims are high in volume and duration**
  - **Neoplasm and Injury, while less in number, have longer durations**

ETF Feedback

- **ETF Ombudspersons reported the following disability contacts (includes all disability programs):**
  - **2003 – 125 contacts**
  - **2004 – 176 contacts**
  - **2005 – 23 contacts**
  - **2006 – 16 contacts**
  - **2007 – 19 contacts**
- **Typically, when an ETF ombudsperson contact occurs, Quality Assurance Services Bureau staff focus primarily on educating members on processes (including administrative review rights) and facilitating communication between the member and the benefit administrator.**
- **Because Aetna has retained the same staff on ETF's account for years, the analysts have the experience and confidence to successfully address issues with the clamant directly that may have been escalated before.**

Ombudsperson Activity

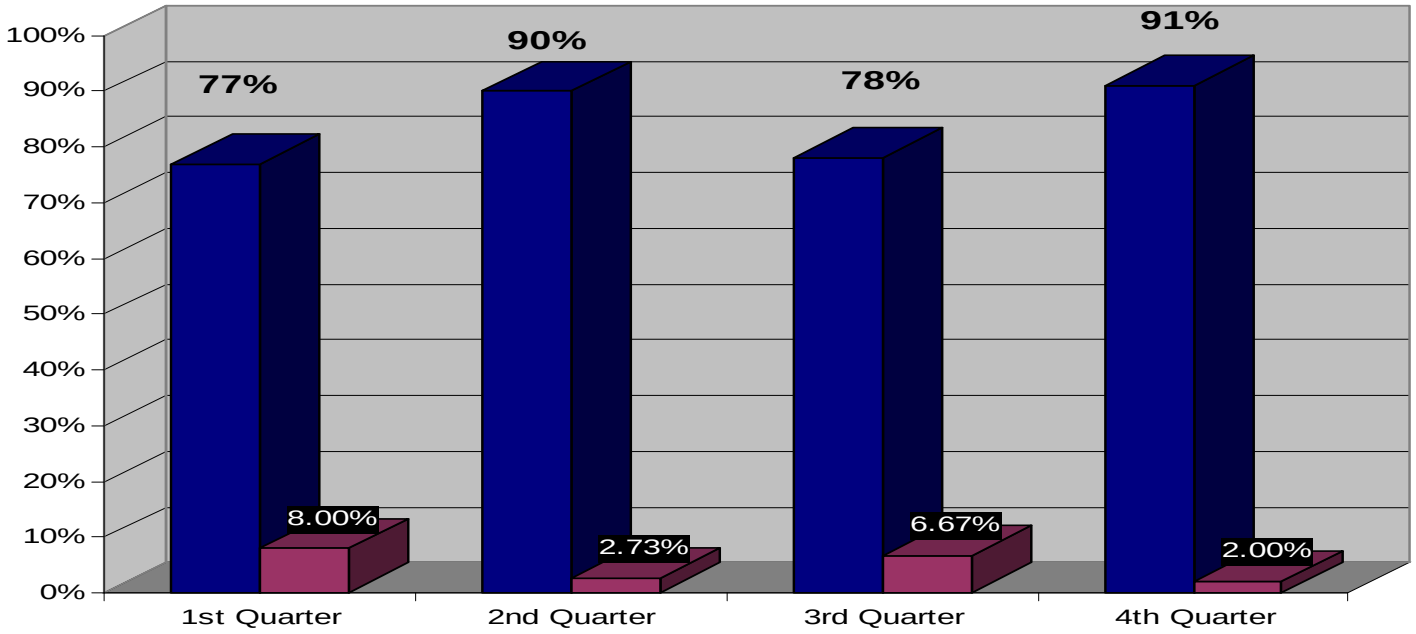
- **Aetna's Ombudsperson issues have been reduced in number and time to resolve.**
- **Aetna Ombudsperson contacts:**
  - **2005 approximately 5 contacts per month**
  - **2006 approximately 1 contact per month**
  - **2007 approximately 1 contact per month**
- **These contacts are usually:**
    - **adverse claim decision**
    - **overpayment**
    - **process education**

2007 Performance Measures

- **Phone Statistics- Time to Answer**
- **Correspondence Tracking and Turnaround**
- **Evidence of Insurability - EOI Processing**

2007 Telephone Performance

Quarter	Received	Level of Service	Abandoned
1st Quarter	2,952	77%	8.00%
2nd Quarter	3,355	90%	2.73%
3rd Quarter	3,310	78%	6.67%
4th Quarter	2,157	91%	2.00%
Annual	**11,774**	**84%**	**4.85%**



Performance Standard = 85% and 4.5%

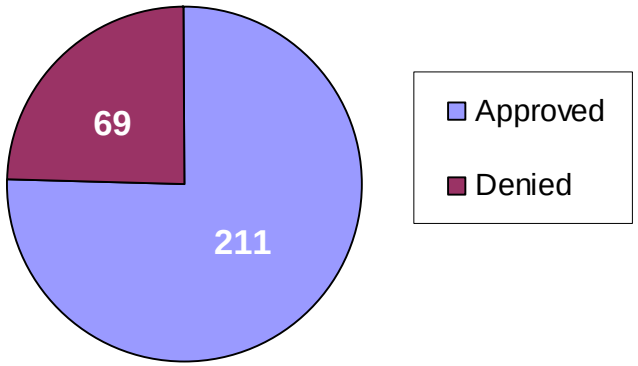
Phone Performance
4 Year Study

	2007	2006	2005	2004
Number of phone calls	11,774	10,795	16,617	26,834
Answered-30 seconds	84%	83%	91 %	85%
Abandoned	4.85%	4.17%	3.7%	3.6%

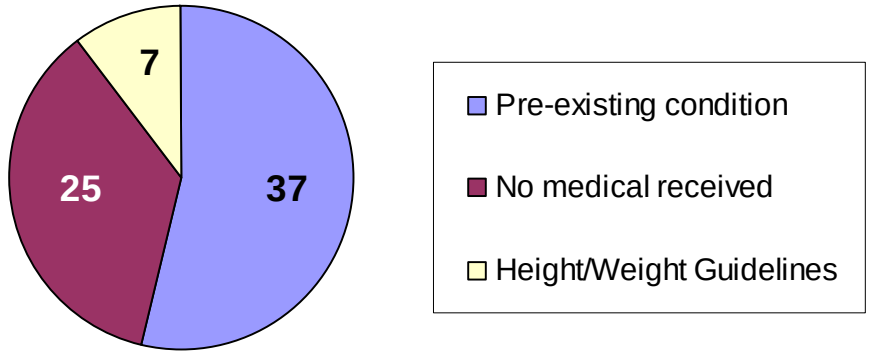
- After three years of decline in number of phone calls, there was a slight increase in calls in 2007:
  - Assignment of claim owner at intake decreased the call volume dramatically from 2004
  - The slight increase in 2007 is not of great concern but did lead to slight resource shift to fill the need
  - Less calls go through Ombudsman line and are now managed by well versed analyst staff
- Aetna has exceeded on phone performance the last 2 quarters and intends to exceed levels for the remainder of 2008.

Evidence of Insurability 2007

Evidence of Insurability- 280 Applications



Denied EOI Applications



- **Initiation within 5 days**:

98%
(98% in 2006)
standard is 95%

- **Determination within 30 days:**

99%
(99% in 2006)
standard is 98%

- **Determination communicated within 4 days:**

99%
(99% in 2006)
standard is 100%

2007 Customer Service Measures

Telephone Performance- **85% of calls answered in 30 seconds:**

2007- 84%- Standard Not Met

Telephone Abandonment Rate - No more than 4.5% will be abandoned:

2007 – 4.85%- Standard Not Met

Silent Monitor Audit of Intake - 95% pass quality- Polite, Accurate and Professional

2007 – 100% Standard Met

Silent Monitor Audit Clinical - 95% pass quality- Polite, Accurate and Professional

2007 - 100% Standard Met

Customer Satisfaction Surveys - 90%Respondents will give overall rating of Excellent or Good

2007 – 98%- Standard Met

Claims/Experience Study- 2007

1. Claims Counts 2007 by Product

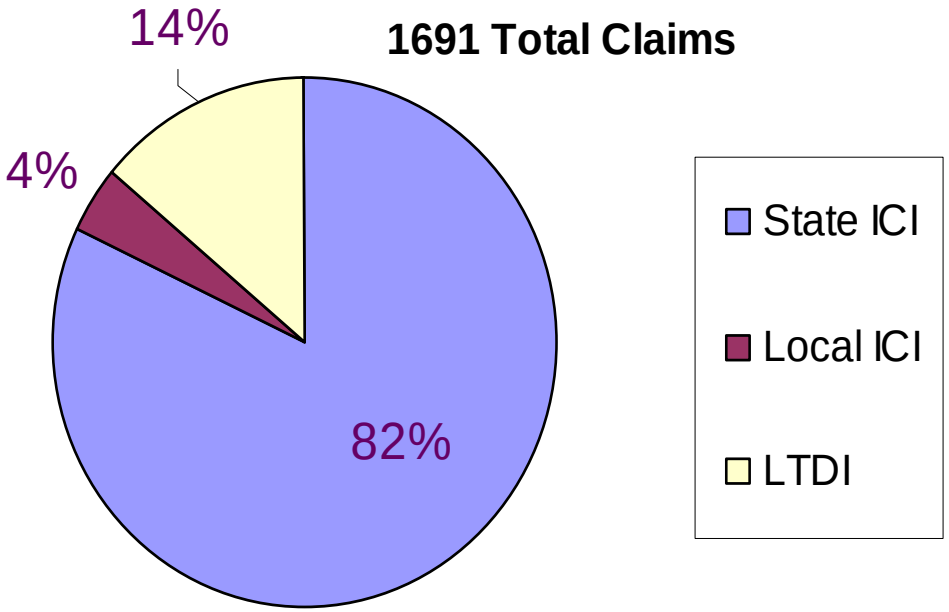
2. Individual Program Utilization

a) State ICI- STD/LTD
   - Claims, Agency, Gender, Diagnostic Categories

b) Local ICI- STD/LTD
   - Claims, Agency, Gender, Diagnostic Categories

c) LTDI
   - Claims, Agency, Gender, Diagnostic Categories

2007 Overall New Claim Numbers

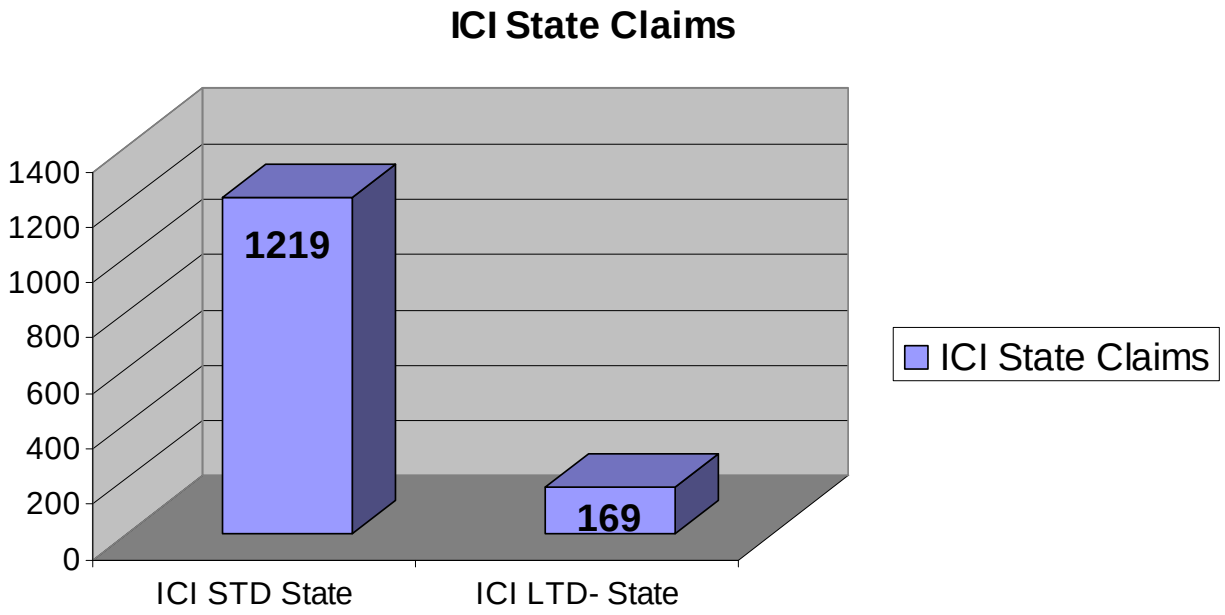


State ICI - 1388 claims

Local ICI - 70 claims

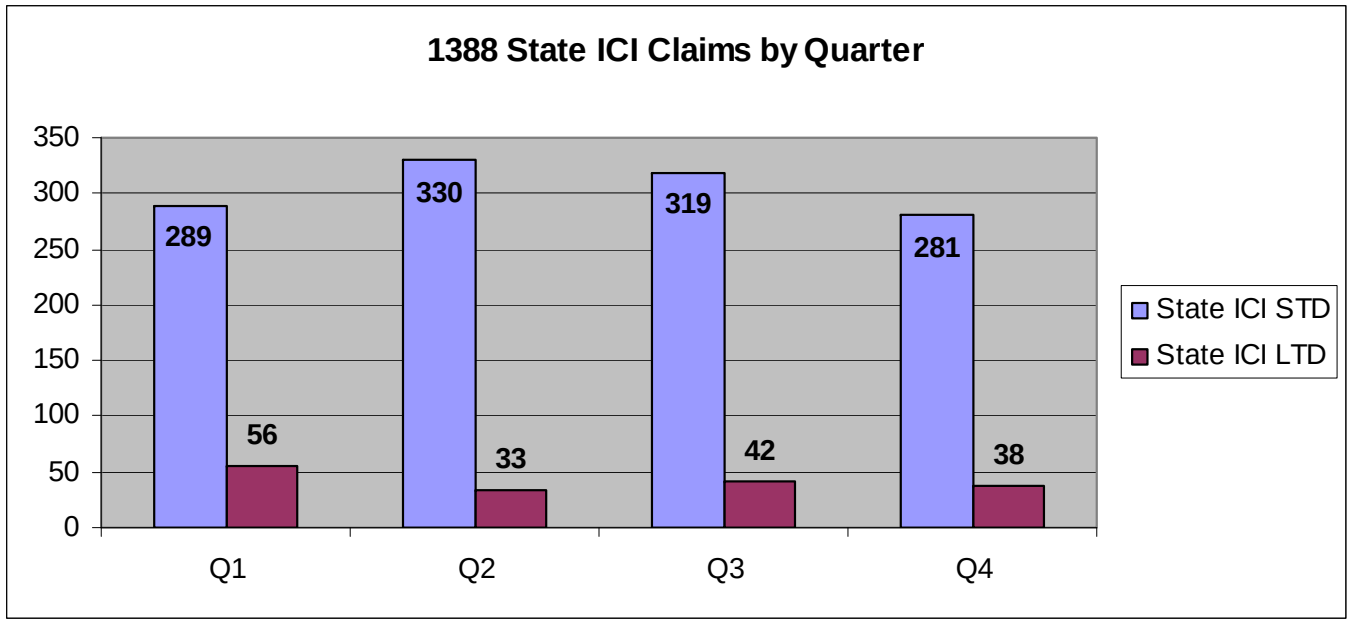
LTDI- 233 claims

2007 ICI State Program Claim Counts



- **1219 New ICI State Short Term Disability (STD) claims in 2007**
- **169 State ICI claims moved into the Long Term Disability (LTD) phase:**
  - **An ICI STD claim becomes LTD after one year of duration**

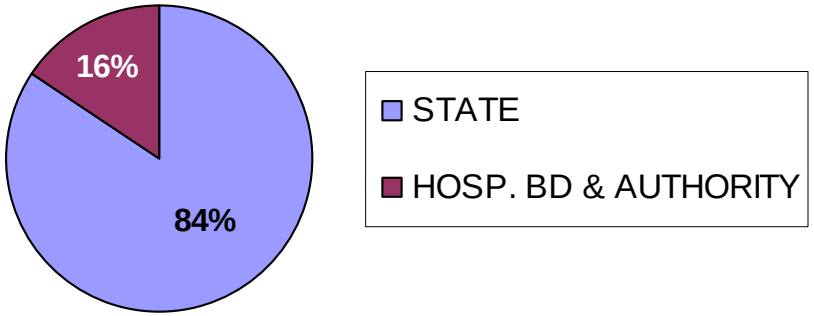
ICI STATE STD/LTD by Quarter



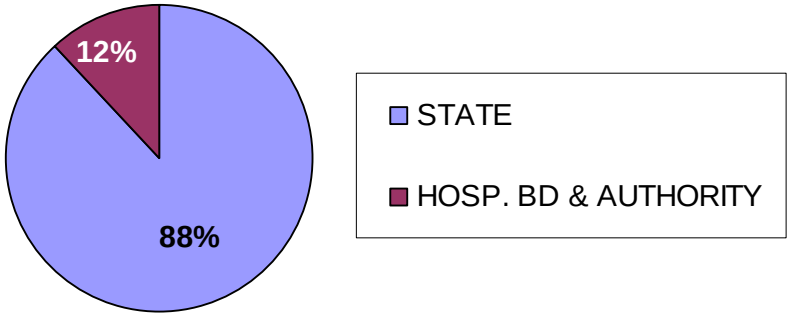
- There is a slight seasonality for STD claims within Q2 and Q3
- LTD claims are relatively steady across all quarters
- Just over 10% of STD claims will become an LTD claim

2007 State ICI Claims by Employer Type

ICI State STD by Employer

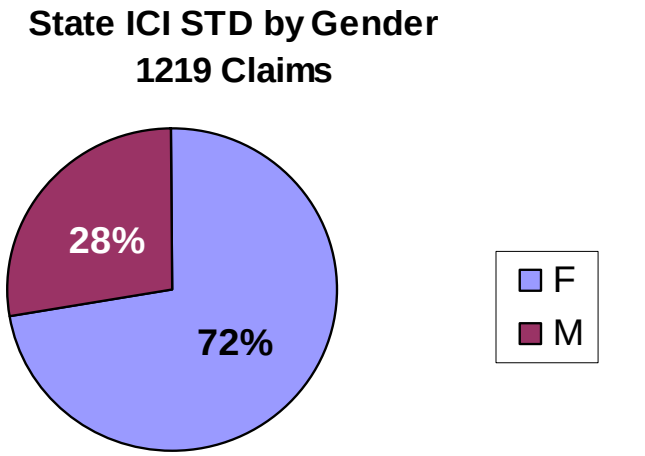


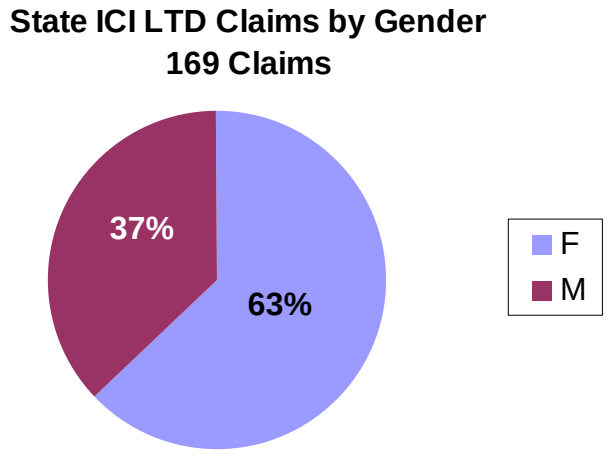
ICI State LTD By Employer



- **All ICI STD Claims are recorded as either**
  - **State or Hospital**
- **Of the 1219 STD Claims**
  - **1029 were State**
  - **190 were Hospital**
- **Of the 169 ICI LTD Claims**
  - **149 were State**
  - **20 were Hospital**

2007 State ICI Claims by Gender





- **ICI State STD**
  - **881 have been initiated by the Female population**
  - **338 by the Male population**
  - **Maternity as an exclusive category for Female supports the ratio- and is common as an STD statistic**
- **ICI LTD**
  - **106 Claims- Female**
  - **63 Claims- Male**

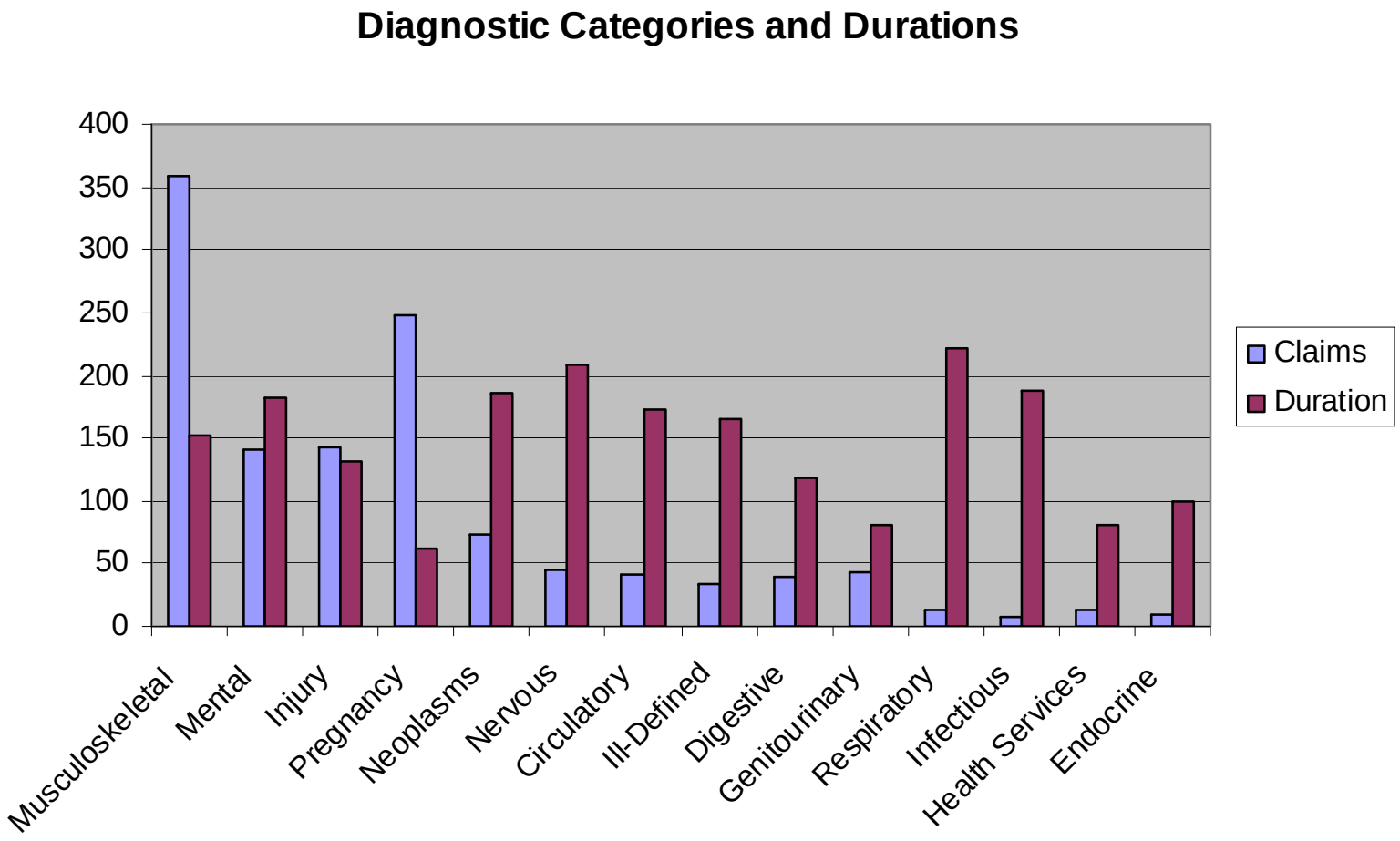
2007 State ICI STD Claims by Disability

Top 14 Categories

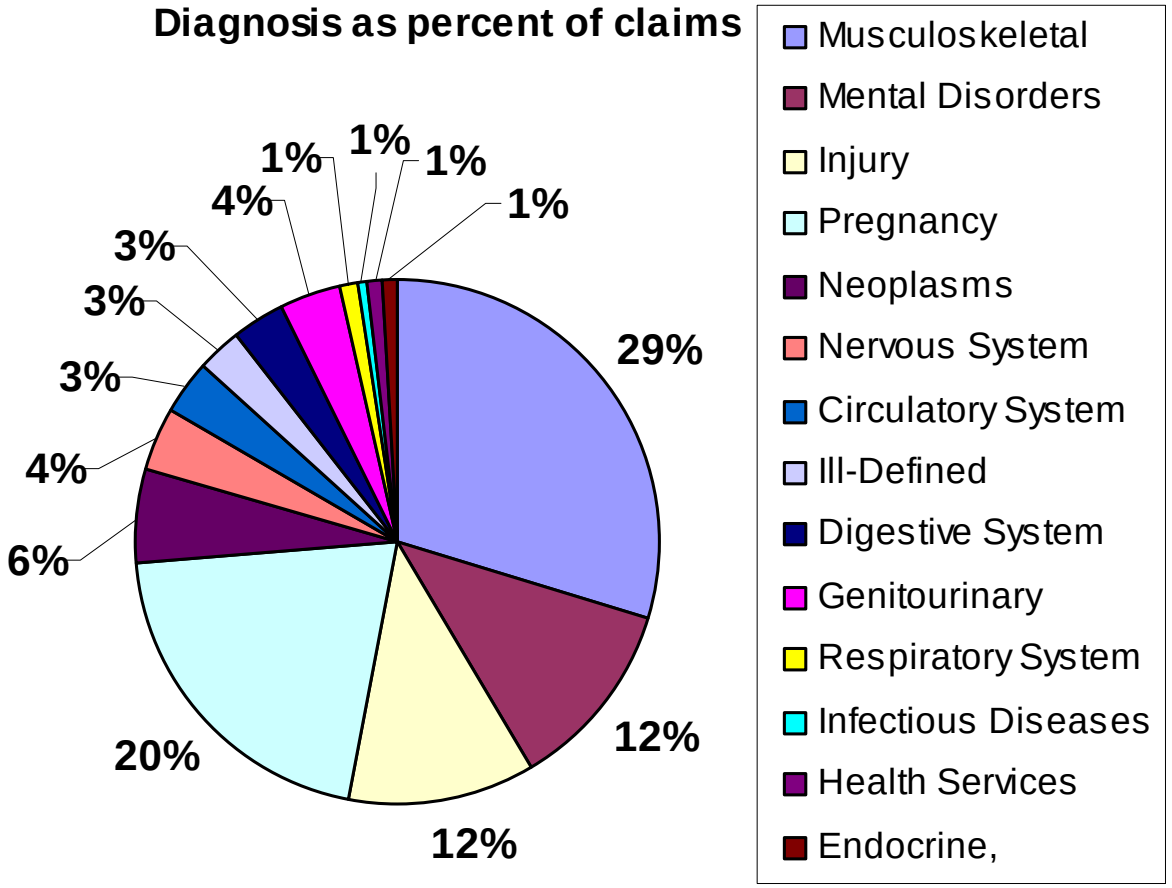
Benefit	Diagnosis	Claims	Days Lost	Duration
STDICI	Musculoskeletal	358	54628	152
STDICI	Mental Disorders	141	25717	182
STDICI	Injury and Poisoning	142	18878	132
STDICI	Pregnancy, Childbirth	248	15443	62
STDICI	Neoplasm	73	13515	185
STDICI	Nervous/Sense Organs	45	9410	209
STDICI	Circulatory	41	7096	173
STDICI	Ill-Defined	34	5671	166
STDICI	Digestive	40	4752	118
STDICI	Genitourinary	43	3522	81
STDICI	Respiratory	13	2877	221
STDICI	Infectious	8	1496	187
STDICI	Health Services	14	1147	81
STDICI	Endocrine	9	896	99

- ICI State STD comprises a majority of the volume and claim processing in administration of ETF's programs
- The chart details what medical conditions drive absence

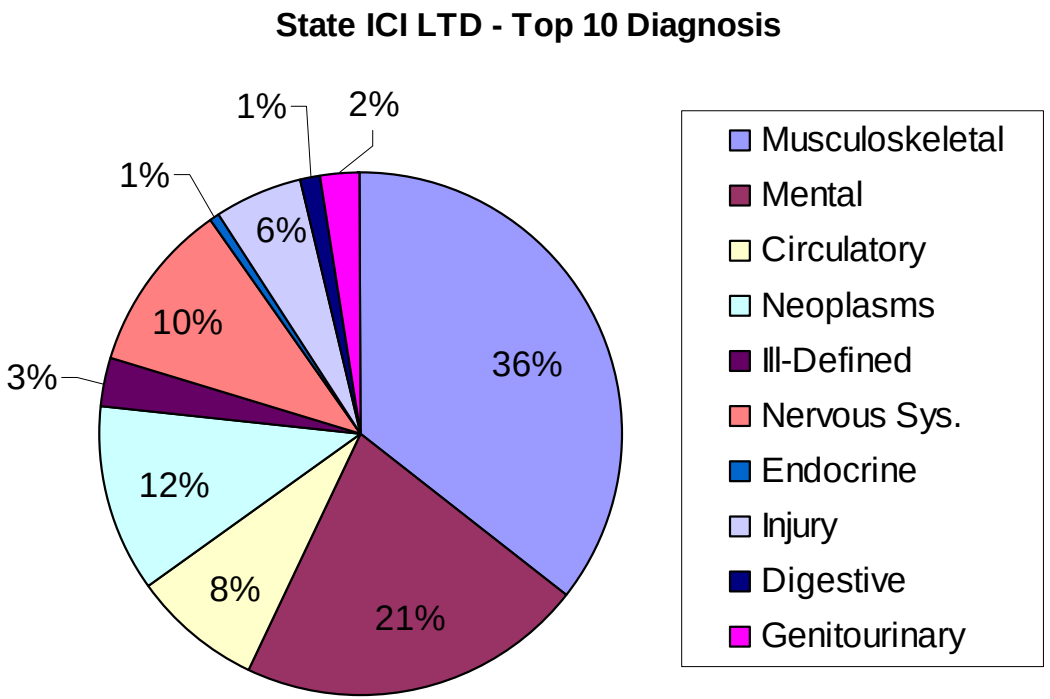
Diagnostic Categories and Durations 2007 ICI STD



State ICI STD Diagnosis as a Percent of Claims Top 14



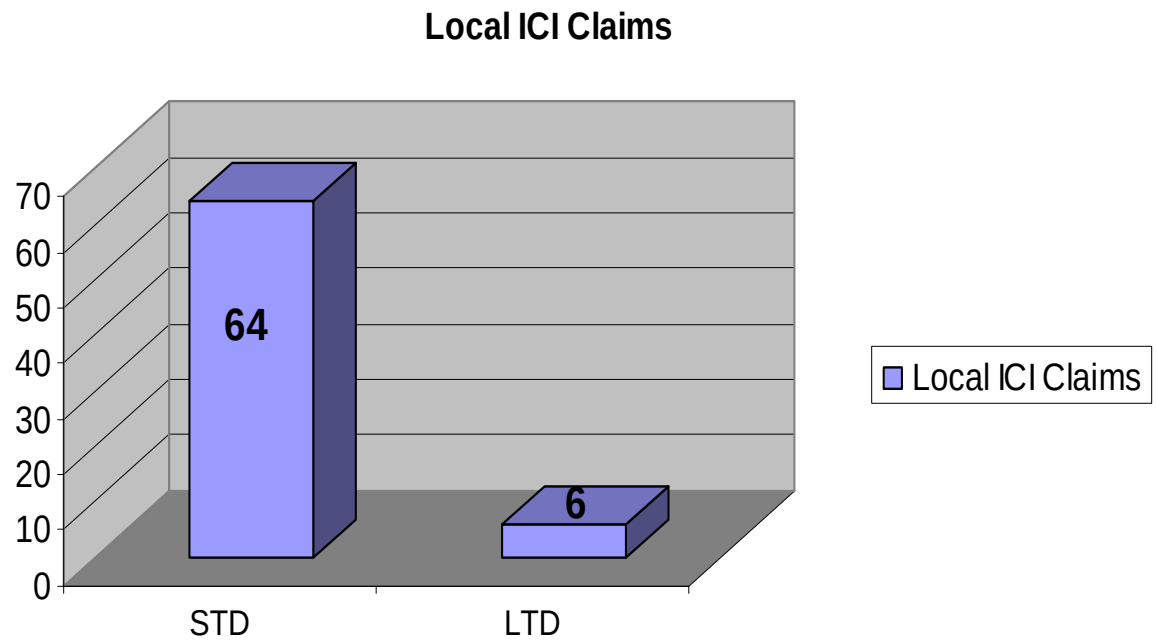
2007 State ICI LTD Claims by Diagnosis



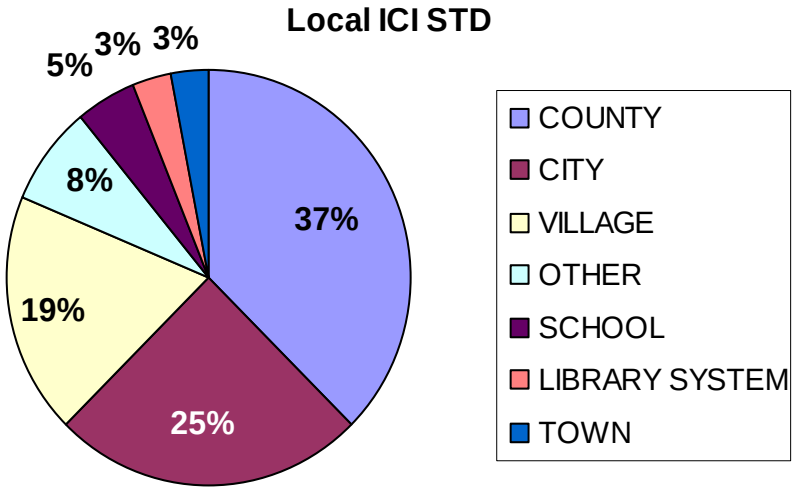
Diagnosis	Claims
Musculoskeletal	58
Mental	35
Circulatory	13
Neoplasm	19
Ill-Defined	5
Nervous Sys.	17
Endocrine	1
Injury	9
Digestive	2
Genitourinary	4

2007 Local ICI Claims Statistics

- **64 Short-Term Disability claims are a majority of the Local ICI claims**
- **There were 6 Local ICI LTD claims**

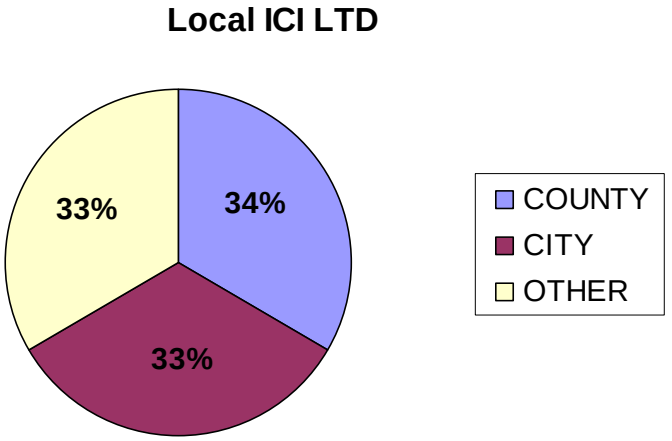


2007 Local ICI Claims by Employer Type

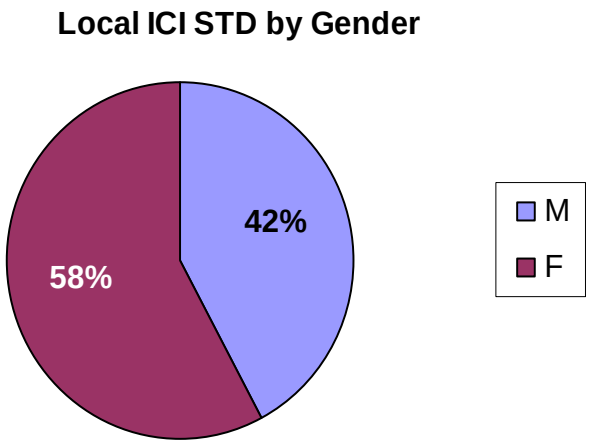


Local ICI	STD
COUNTY	24
CITY	16
VILLAGE	12
OTHER	5
SCHOOL	3
LIBRARY SYSTEM	2
TOWN	2

Local ICI	LTD
COUNTY	2
CITY	2
OTHER	2

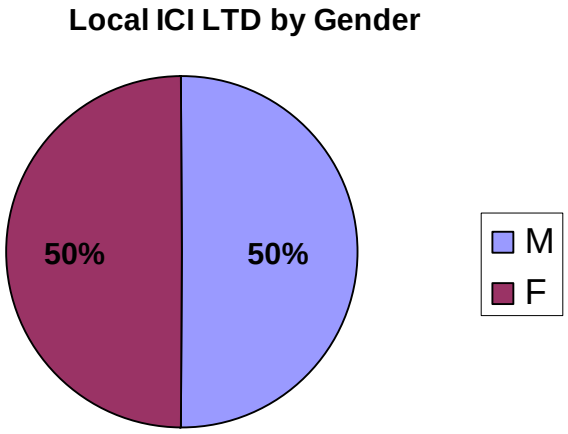


2007 Local ICI Claims by Gender



Local ICI STD

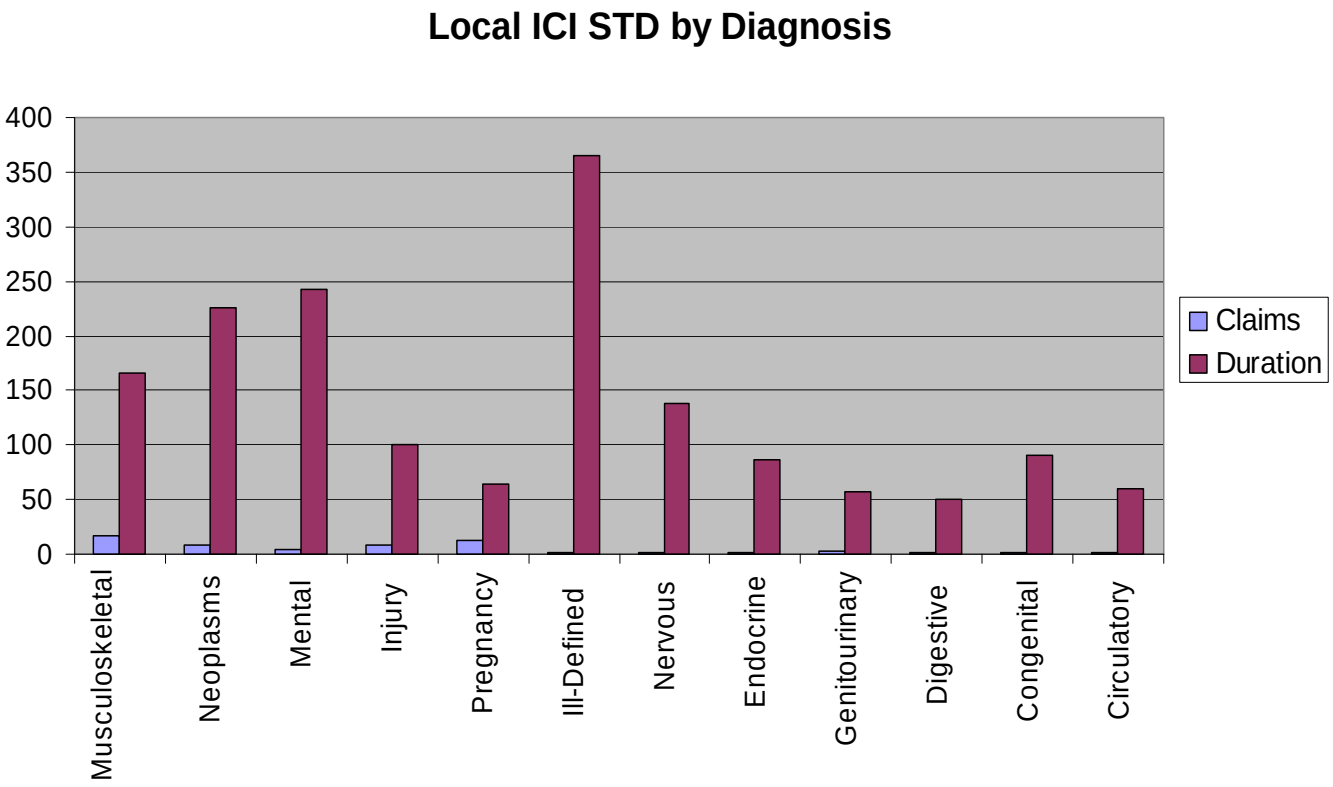
- **37 Female**
- **27 Males**



Local ICI LTD

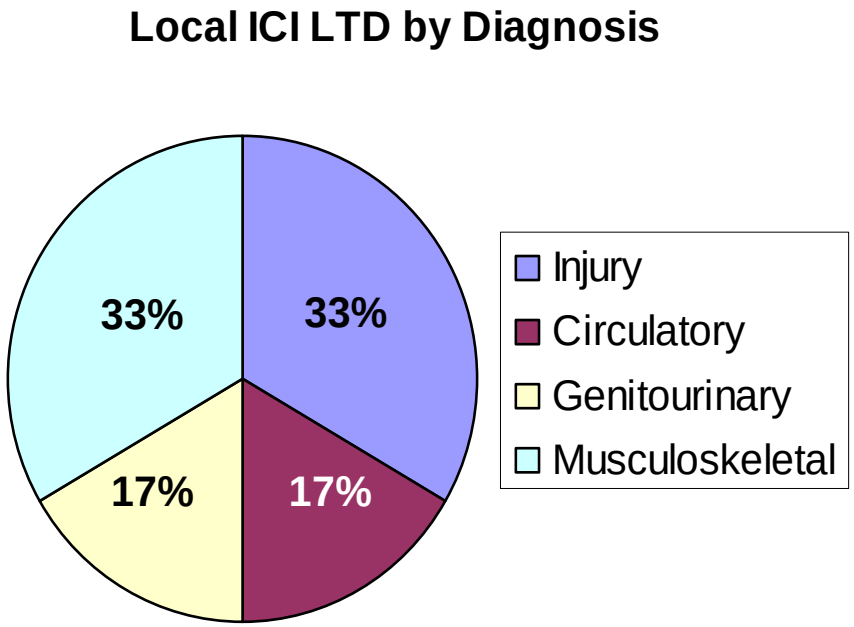
- **3 Female**
- **3 Male**

2007 Local ICI STD Claims by Disability Type



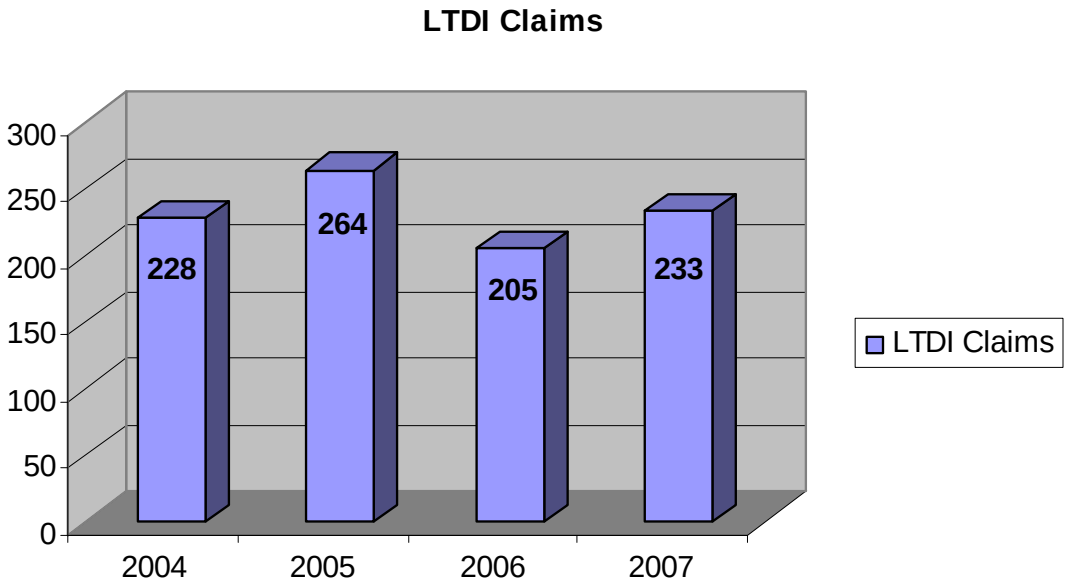
Diagnosis	Claims	Duration
Musculoskeletal	17	166
Neoplasm	9	226
Mental	4	242
Injury	9	101
Pregnancy	13	64
Ill-Defined	1	365
Nervous	2	138
Endocrine	2	87
Genitourinary	3	57
Digestive	2	50
Congenital	1	91
Circulatory	1	60

2007 Local ICI LTD Claim by Disability Type



Diagnosis	Claims	Duration
Injury	2	338
Circulatory	1	374
Genitourinary	1	284
Musculoskeletal	2	86

2007 New LTDI Claims



4 year data:

- **2004- 228 LTDI claims**
- **2005- 264 LTDI claims**
- **2006- 205 LTDI claims**
- **2007- 233 LTDI claims**

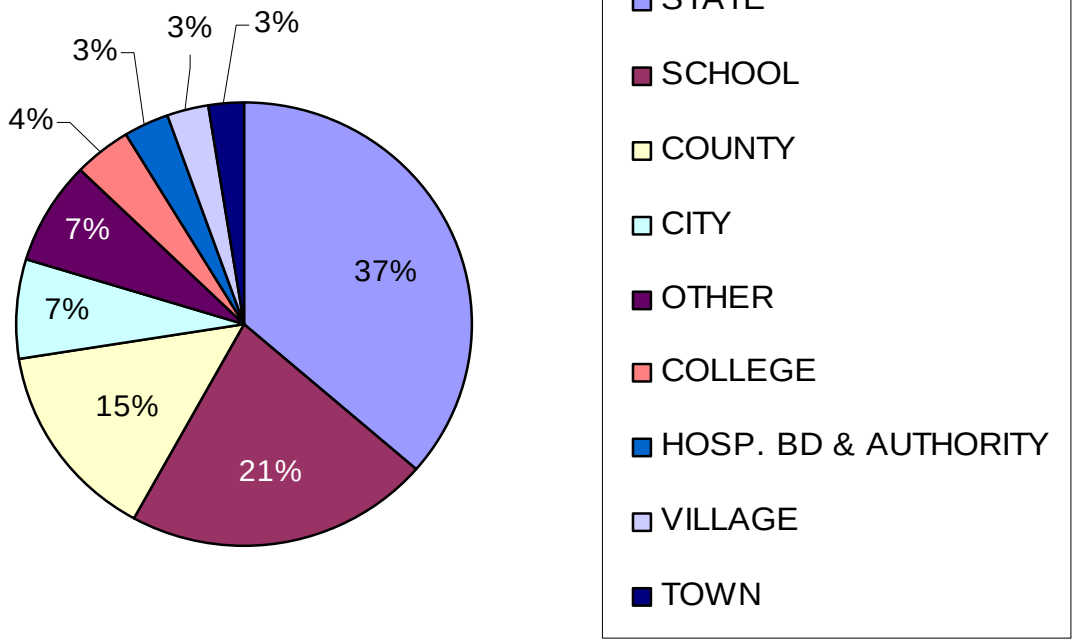
2006 comment:

- **"We'll monitor to see if the drop in LTDI is a trend or is simply a leveling off pattern."**

LTDI has fallen into a level predictable pattern

2007 Total LTDI Claims by Employer Type

Percent LTDI Claims by Employer

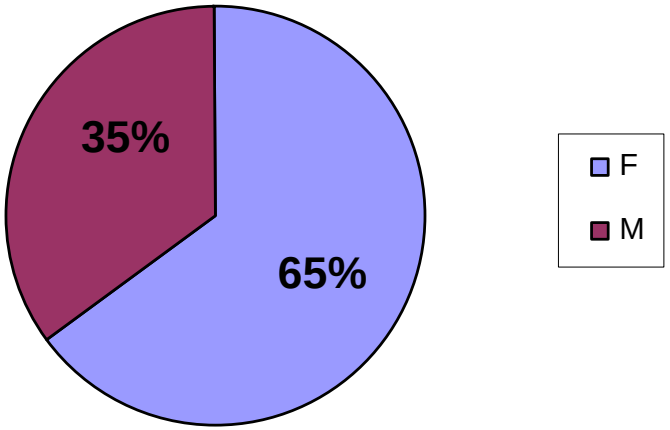


Employer	Claims
STATE	85
SCHOOL	50
COUNTY	34
CITY	17
OTHER	17
COLLEGE	10
HOSP. BD & AUTHORITY	7
VILLAGE	7
TOWN	6

- **LTDI Claims**
  - **State employer is again the majority at 37%**
  - **School employers make up 21%, County employers make up 15%**

2007 Claims by Gender - LTDI

LTDI By Gender

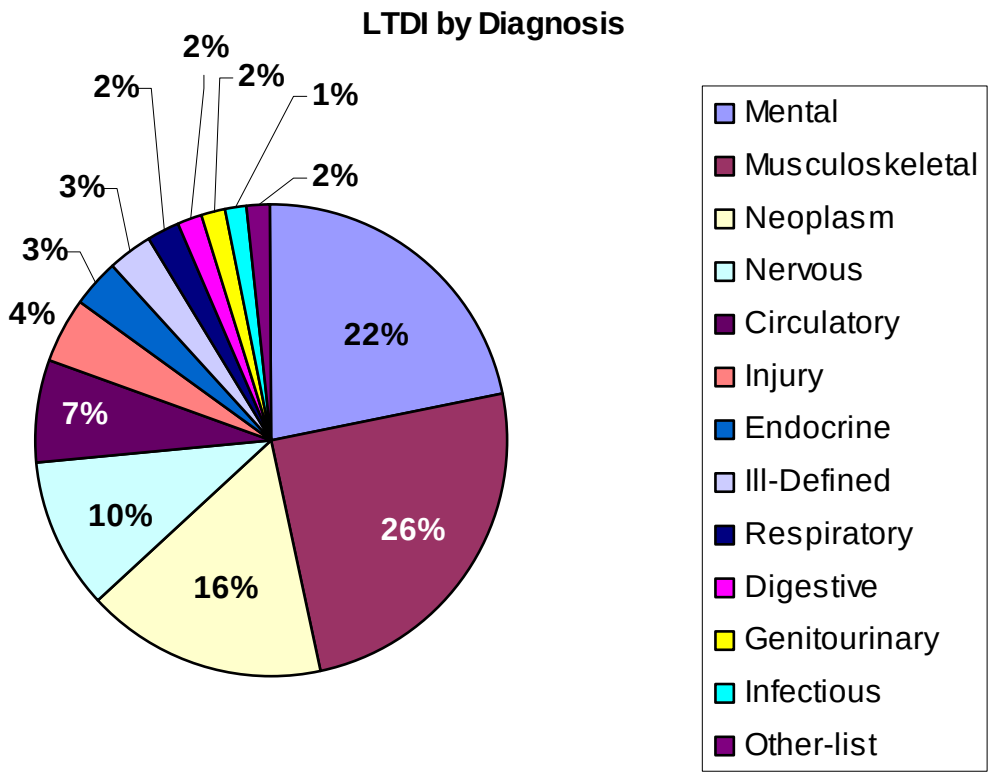


Of the LTDI Claims

- **Female claims are disproportionately higher than male for approved LTDI claims**
- **This lines up with demographics**
- **WRS population:**
  - **36% Male**
  - **64% Female**

2007 LTDI Claims by Disability Type

Diagnosis	Claims
Mental	51
Musculoskeletal	57
Neoplasm	38
Nervous	24
Circulatory	17
Injury	10
Endocrine	8
Ill-Defined	7
Respiratory	5
Digestive	4
Genitourinary	4
Infectious	3
Other- list	5



Approach for 2008

- Maintain customer service levels
- Maintain staffing strength, experience and numbers
- Agree upon future program evolution - contract
- Look for program efficiency and enhancement opportunities:
  - Continue online technology to ETF team- claims status, statistical reporting
  - Continue to build relationships with employers
- Look to ETF/GIB for priority guidance
- Protect program strengths while evolving the program

Questions & Answers

2007 STATE OF WISCONSIN UTILIZATION REPORT
Table of Contents

2007 STATE OF WISCONSIN UTILIZATION REPORT
Table of Contents

2007 STATE OF WISCONSIN UTILIZATION REPORT
Table of Contents

2007 STATE OF WISCONSIN UTILIZATION REPORT
Table of Contents

WPS HEALTH INSURANCE

State of Wisconsin

Section 1: State Employee Trust Funds

Insuring **Wisconsin's** Health *Since 1946*

Executive Summary

Member / Demographic Data

Total enrollment was 13,957 as of January 2008, down from 14,489 members in January 2007. The reduction in membership was mainly due to HMO offerings being made available in Marinette, Pierce and Ashland Counties in January 2008.

The **Standard Plan** membership is much older than the normative distribution with 41.4% of membership over the age of 55 compared to the benchmark of 16.4%. 75.9% of the Standard Plan participants live within Wisconsin. Much of the Standard Plan population is located near larger metropolitan areas in Wisconsin with 25.4% of the population living in Dane County and 17.4% living in Milwaukee County.

The ages of the **SMP Plan** members by comparison are in line with the normative distribution. The SMP Plan membership is almost entirely within Wisconsin, with a majority of the population living in Marinette and Pierce Counties. Only 4.0% of the population lives outside of Wisconsin. In 2008 the SMP Plan will only be available in 9 counties down from the current 12 county region. As of January 2008, this change has resulted in a population reduction from the current 519 members to 161 members.

Claims Data

Summary

In 2007, the Standard Plan was 87.9% higher in overall PMPM claims costs than the SMP Plan. The Standard Plan's enrollment is generally in more expensive urban areas such as Milwaukee and Dane Counties, causing some of the differential. A bigger factor is the difference in demographics between the two plans, which by itself would be expected to raise the Standard Plan's costs another 26% above the SMP Plan. The final piece is simply the anti-selection that the Standard Plan is subject to vs. the other options available to the members. A broader provider panel is more attractive to members who utilize healthcare services and therefore value provider access, despite a larger premium contribution and the presence of modest cost sharing provisions within the benefit plan.

Standard Plan

The Standard Plan has seen an 8.3% increase in overall claim costs between 2006 and 2007, in line with independent trend estimates

The Standard Plan's costs were 47.9% above the benchmark in 2007, which is similar to the 2006 percentage of 45.6%. The variance to the benchmark is primarily a result of the anti-selection resulting from the dual choice open enrollment. Other contributing factors include the location of the Standard Plan's enrolled membership (the higher cost urban areas) and the rich benefit design (relative to the benchmark).

A review of claims by Major Diagnostic Category helps explain some of the benchmark variance as well. Higher than expected costs associated with gastric bypass procedures, combined with an above average outpatient psychiatric benefit and overall higher than expected large claim activity all contributed to the actual claim results being higher than the benchmark.

The Standard Plan has 36 members with claims over $100,000 for a total of $7,719,465 in claim costs. These 36 members represent 22.0% of total claims paid under the Standard Plan. The expected percent of claims over $100,000 for a group of this size is 6.0%, while the actual is 11.7%. The Standard Plan members pay 2.6% of their own medical claims as compared to the benchmark of 7.4%.

WPS paid 68.0% of submitted charges on behalf of the plan.

SMP Plan

For the SMP Plan, the year over year medical PMPM trend was -1.8%, influenced substantially by the change in membership. The SMP Plan was 0.5% above the benchmark for 2007. Facility outpatient services are higher than benchmark, but considering the small size, some variances are expected.

A review of claims by Major Diagnostic Category shows a few categories with significant deviations from the benchmark. However, with the low membership on the plan, the two large claims tend to drive overages related to those conditions.

The SMP Plan has 2 members with claims over $100,000 for a total of $466,192 in claim costs. These members represent 13.6% of total claims paid under the SMP Plan. The SMP Plan members pay almost nothing towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 7-8% of their medical claims.

WPS paid 73.3% of submitted charges on behalf of the plan.

Medicare

The Medicare Plus $1M Plan has seen stable results over the last 2 years. The year over year medical PMPM trend from 2006 to 2007 was 7.3%.

WPS paid 7.0% of submitted charges on behalf of the plan. 80.4% of the charges were paid by Medicare.

Provider Data

For the **Standard Plan**, the top 20 facilities provide 57.1% of the total facility charges for the plan. By far, the largest percent of claims and number of patients came from the University of Wisconsin hospital. 44.4% of professional charges are from the top 20 providers. The University of Wisconsin Medical Foundation is the leading professional provider. Like the facility charges a concentration of the top providers are from the Dane and Milwaukee Counties regions.

For the **SMP Plan**, the top 20 facilities provide 97.3% of the total facility charges for the plan. The largest percentage of paid claims is from Bay Area Medical Center in Marinette. The provider with the second highest amount of paid claims is the University of Wisconsin Hospital, though this was for only one claimant.

74.1% of the paid claims are from the top 20 professional providers. Bay Area / Bellin Health in Marinette was the largest provider, receiving 10.4% of the overall payments, followed by Aurora Medical in Oshkosh at 9.7%.

Benchmarks

The benchmarks used in this report are derived from the experience of WPS large group and self funded business. In general, these groups are a combination of private and public employers, ranging in size from 51 employees to 5,000. All groups have their primary location and the majority of their population in Wisconsin. Only groups with a full year of experience with WPS were included to avoid any biases resulting from seasonality.

Demographic benchmarks are based on calendar year 2007 data. For Medicare classes, demographic benchmarks are based on comparable WPS Medicare enrollment as appropriate.

Claim cost benchmarks are also based on calendar year 2007 data. To make the claim benchmarks more meaningful, they have been adjusted for demographic differences between the specific population profiled in each report and the population in the WPS benchmark. For example, an older population may be expected to have higher prescription drug costs but lower maternity costs. Unless otherwise specified, each claim based benchmark has had such an adjustment made, including not only PMPM costs but days/1000 and cost/day. The factors that go into each adjustment are unique to the particular claim-based statistic. Claim benchmarks are not adjusted, however, for plan benefit differences between the average represented in the WPS benchmark and the specific reported ETF class.

Monthly Membership

The Monthly Membership report in Exhibit 1-A shows monthly membership for the Standard, SMP and Medicare Plus $1M Plans from January 2006 through December 2007.

Enrollment on the **Standard Plan** averaged 4,329 members per month in 2006 compared to 3,901 members per month in 2007, a reduction of 10.0%. Monthly membership within each year stayed relatively stable with increases seen in September and October of each year.

SMP Plan enrollment averaged 8,162 members per month in 2006 compared to 533 members per month in 2007. This reduction is the result of a reduced service area in which the plan is available, dropping from 27 counties in 2006 to 12 counties in 2007.

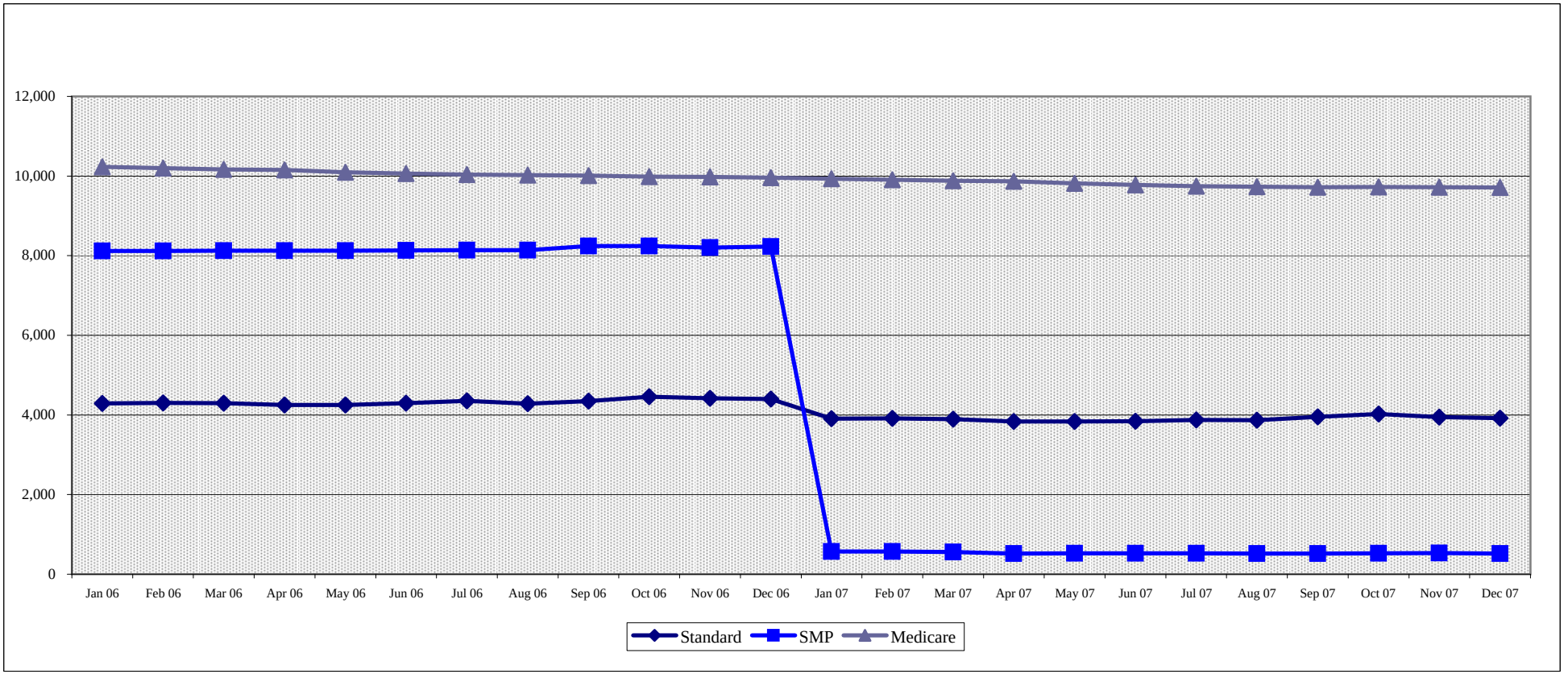
The **Medicare Plus $1M Plan** enrollment is experiencing a very gradual decline in membership. Between Jan 2006 and December 2007, enrollment dropped from 10,234 to 9,714, or a reduction of 5% over the course of the two years.

STATE EMPLOYEE TRUST FUNDS

Monthly Membership

January 2006 through December 2007

Exhibit 1-A



	EFFECTIVE MONTH																							
	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
Standard	4,292	4,303	4,293	4,248	4,249	4,294	4,354	4,285	4,348	4,456	4,420	4,400	3,905	3,916	3,896	3,836	3,835	3,842	3,875	3,868	3,952	4,021	3,948	3,922
SMP	8,118	8,122	8,125	8,126	8,128	8,132	8,138	8,137	8,241	8,245	8,203	8,226	569	568	560	519	527	524	524	520	521	522	531	519
Medicare	10,234	10,201	10,167	10,151	10,097	10,060	10,036	10,023	10,012	9,985	9,980	9,958	9,935	9,906	9,881	9,867	9,818	9,775	9,747	9,732	9,722	9,727	9,720	9,714

Enrollment by Plan

The Enrollment by Plan report shown in Exhibit 2-A shows the December 2007 membership for the Standard, SMP and Medicare Plus $1M Plans at the class level. For each class, member average age and gender distribution is shown. The age/gender factor is included as an index intended to represent expected plan cost based on the age and gender of each member, without regard to plan design, health, etc. The age/gender factor is not shown for the Medicare Plus $1M Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

The average age of the Standard Plan is 43.7 years, 6.2 years older than the 36.5 average age of the smaller SMP Plan. Based on the age/gender factors for December 2007, we would expect the demographics alone would cause the Standard Plan to be 26% higher in claim costs than the SMP Plan, everything else being equal.

Exhibit 2-A

STATE EMPLOYEE TRUST FUNDS
Enrollment by Plan
December 2007

Plan	Class	# of Members	Average Member Age	Member Gender Distribution Female	Member Age/ Gender Factor
Standard	Regular	2,816	42.8	53.5%	1.594
	Graduate Assistant (including GA continuation)	387	27.9	49.4%	0.924
	Continuation	20	35.0	35.0%	1.105
	Annuitants	699	56.1	68.4%	2.318
	Subtotal	**3,922**	**43.7**	**55.6%**	**1.655**
SMP	Regular	470	35.0	50.6%	1.235
	Graduate Assistant (including GA continuation)	4	33.3	50.0%	0.995
	Continuation	1	42.0	0.0%	0.912
	Annuitants	44	53.1	50.0%	2.176
	Subtotal	**519**	**36.5**	**50.5%**	**1.313**
Medicare Plus One Million	Single	4,549	80.2	72.6%	N/A
	One Over	245	69.8	10.6%	N/A
	Two Over	4,920	75.8	50.1%	N/A
	Subtotal	**9,714**	**77.7**	**59.6%**	**N/A**
ETF Grand Total		**14,155**	**66.8**	**58.2%**	**N/A**

Member Census Grids

The Member Census Grid breaks down the December 2007 membership into age and gender categories for the Standard, SMP and Medicare Plus $1M Plans. The Standard and SMP distributions are compared to a benchmark distribution based on WPS large group business as described in the Executive Summary. The benchmark distribution for the Medicare plan is based on WPS Medicare Supplement business.

Standard Plan

The Standard Plan membership in Exhibit 3-A shows the plan having a much older actual population than the normative distribution with 41.4% of membership over the age of 55 compared to the benchmark of 16.4%. The broad provider panel and out of state membership produce an upward bias on the average age. Older members tend to seek more medical care and tend to select a broader panel of providers for that care. Since the Standard Plan has a broader panel of providers, this causes the average age to be higher. Secondly, the Standard Plan is the only out of state offering. Therefore, all retirees who move out of state will select the Standard Plan, again contributing to a higher average age.

Also corresponding to the older than expected membership is the smaller than expected population of children with only 15.8% of the membership under the age of 20 compared to the benchmark of 29.7%. The Standard Plan also has a slightly higher than normal female population with 55.6% female, compared to the benchmark of 51.8%.

SMP Plan

The SMP Plan membership shown in Exhibit 3-B by comparison is in line with the normative distribution with only a slightly older population as compared to the benchmark. The SMP Plan distribution shows 52.3% of the population above age 40 compared to the benchmark of 43.4%. The SMP Plan has more males as a percentage when compared to the benchmark.

Medicare

The Medicare Plus $1M Plan membership is shown in Exhibit 3-C. The population over the age of 65 is distributed evenly, with most age bands containing about 20% of the population.

Exhibit 3-A

STATE EMPLOYEE TRUST FUNDS
Member Census Grid - Standard
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	324	8.3%	14.4%
20 - 24	136	3.5%	3.7%
25 - 29	94	2.4%	3.5%
30 - 34	99	2.5%	3.3%
35 - 39	98	2.5%	3.9%
40 - 44	114	2.9%	4.5%
45 - 49	159	4.1%	5.0%
50 - 54	223	5.7%	5.0%
55 - 59	333	8.5%	4.3%
60 - 64	493	12.6%	2.7%
65 +	109	2.8%	1.5%
Total	**2,182**	**55.6%**	**51.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	295	7.5%	15.3%
20 - 24	135	3.4%	3.3%
25 - 29	113	2.9%	2.7%
30 - 34	73	1.9%	3.0%
35 - 39	82	2.1%	3.5%
40 - 44	90	2.3%	4.0%
45 - 49	103	2.6%	4.3%
50 - 54	161	4.1%	4.2%
55 - 59	196	5.0%	3.8%
60 - 64	339	8.6%	2.6%
65 +	153	3.9%	1.5%
Total	**1,740**	**44.4%**	**48.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	619	15.8%	29.7%
20 - 24	271	6.9%	7.0%
25 - 29	207	5.3%	6.2%
30 - 34	172	4.4%	6.3%
35 - 39	180	4.6%	7.4%
40 - 44	204	5.2%	8.5%
45 - 49	262	6.7%	9.3%
50 - 54	384	9.8%	9.2%
55 - 59	529	13.5%	8.1%
60 - 64	832	21.2%	5.3%
65 +	262	6.7%	3.0%
Total	**3,922**	**100.0%**	**100.0%**

Membership Distribution

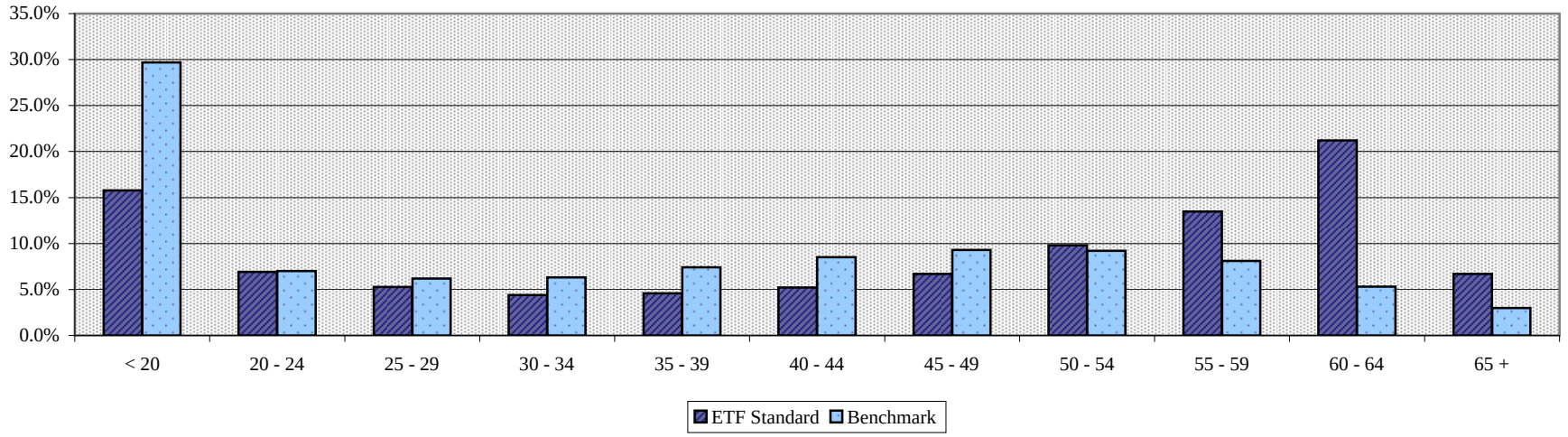


Exhibit 3-B

STATE EMPLOYEE TRUST FUNDS
Member Census Grid - SMP
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	73	14.1%	14.4%
20 - 24	14	2.7%	3.7%
25 - 29	12	2.3%	3.5%
30 - 34	18	3.5%	3.3%
35 - 39	14	2.7%	3.9%
40 - 44	24	4.6%	4.5%
45 - 49	30	5.8%	5.0%
50 - 54	25	4.8%	5.0%
55 - 59	29	5.6%	4.3%
60 - 64	20	3.9%	2.7%
65 +	3	0.6%	1.5%
Total	**262**	**50.5%**	**51.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	65	12.5%	15.3%
20 - 24	13	2.5%	3.3%
25 - 29	9	1.7%	2.7%
30 - 34	10	1.9%	3.0%
35 - 39	20	3.9%	3.5%
40 - 44	22	4.2%	4.0%
45 - 49	26	5.0%	4.3%
50 - 54	30	5.8%	4.2%
55 - 59	30	5.8%	3.8%
60 - 64	29	5.6%	2.6%
65 +	3	0.6%	1.5%
Total	**257**	**49.5%**	**48.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	138	26.6%	29.7%
20 - 24	27	5.2%	7.0%
25 - 29	21	4.0%	6.2%
30 - 34	28	5.4%	6.3%
35 - 39	34	6.6%	7.4%
40 - 44	46	8.9%	8.5%
45 - 49	56	10.8%	9.3%
50 - 54	55	10.6%	9.2%
55 - 59	59	11.4%	8.1%
60 - 64	49	9.4%	5.3%
65 +	6	1.2%	3.0%
Total	**519**	**100.0%**	**100.0%**

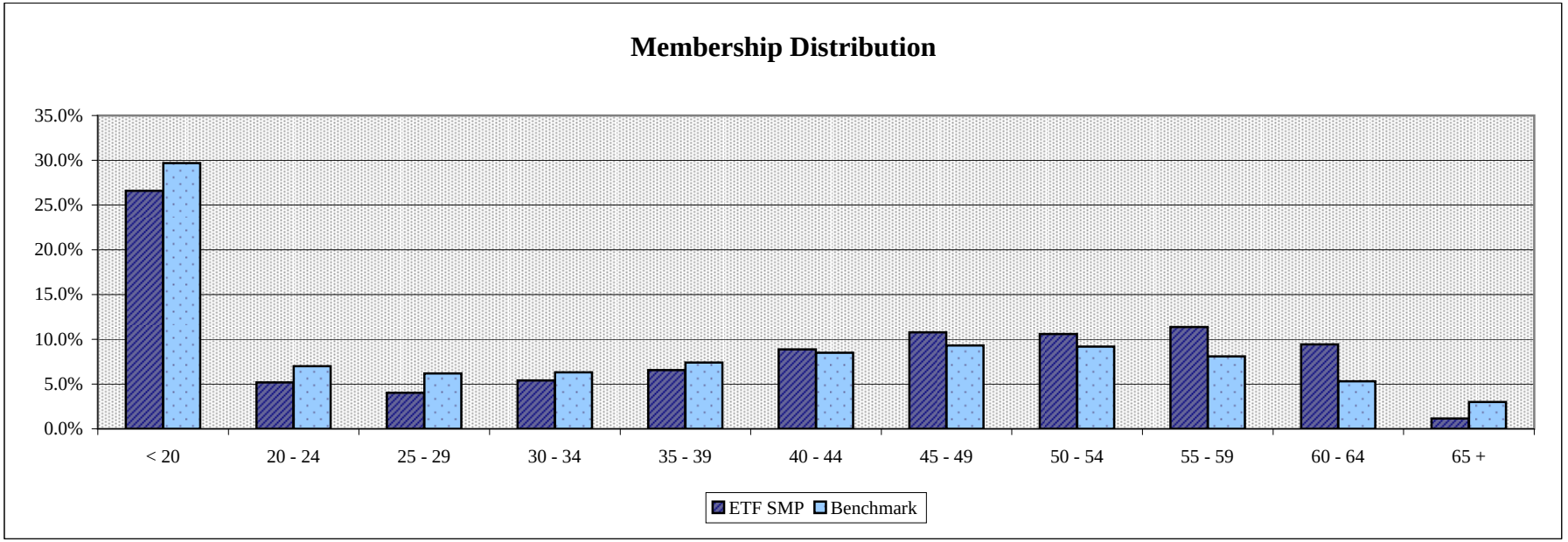


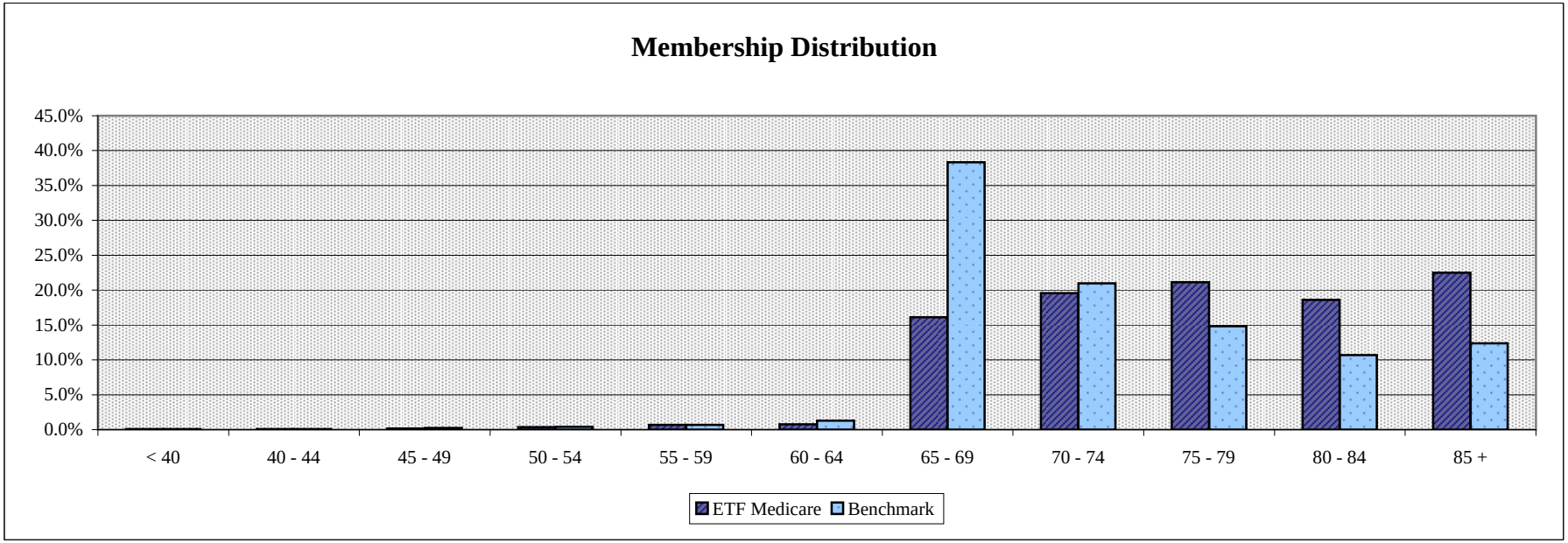
Exhibit 3-C

STATE EMPLOYEE TRUST FUNDS
Member Census Grid - Medicare Plus One Million
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 40	3	0.0%	0.1%
40 - 44	2	0.0%	0.0%
45 - 49	12	0.1%	0.2%
50 - 54	25	0.3%	0.2%
55 - 59	51	0.5%	0.4%
60 - 64	47	0.5%	0.7%
65 - 69	938	9.7%	20.7%
70 - 74	1,047	10.8%	10.9%
75 - 79	1,127	11.6%	8.3%
80 - 84	1,059	10.9%	6.5%
85 +	1,481	15.2%	8.9%
Total	**5,792**	**59.6%**	**56.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 40	4	0.0%	0.0%
40 - 44	4	0.0%	0.0%
45 - 49	3	0.0%	0.1%
50 - 54	9	0.1%	0.2%
55 - 59	16	0.2%	0.3%
60 - 64	28	0.3%	0.6%
65 - 69	626	6.4%	17.7%
70 - 74	855	8.8%	10.1%
75 - 79	924	9.5%	6.5%
80 - 84	747	7.7%	4.2%
85 +	706	7.3%	3.5%
Total	**3,922**	**40.4%**	**43.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 40	7	0.1%	0.1%
40 - 44	6	0.1%	0.1%
45 - 49	15	0.2%	0.3%
50 - 54	34	0.4%	0.4%
55 - 59	67	0.7%	0.7%
60 - 64	75	0.8%	1.3%
65 - 69	1,564	16.1%	38.3%
70 - 74	1,902	19.6%	21.0%
75 - 79	2,051	21.1%	14.8%
80 - 84	1,806	18.6%	10.7%
85 +	2,187	22.5%	12.4%
Total	**9,714**	**100.0%**	**100.0%**



Wisconsin Enrollment

The Wisconsin Enrollment map in Exhibit 4-A visually shows how the membership for the Standard and SMP Plans are dispersed throughout Wisconsin. The map shows enrollment as of December 1, 2007. Each of the dots represents one address. Members of the SMP plan that appear to be living outside the available SMP county region are commonly dependent students. Exhibit 4-B shows the same information numerically.

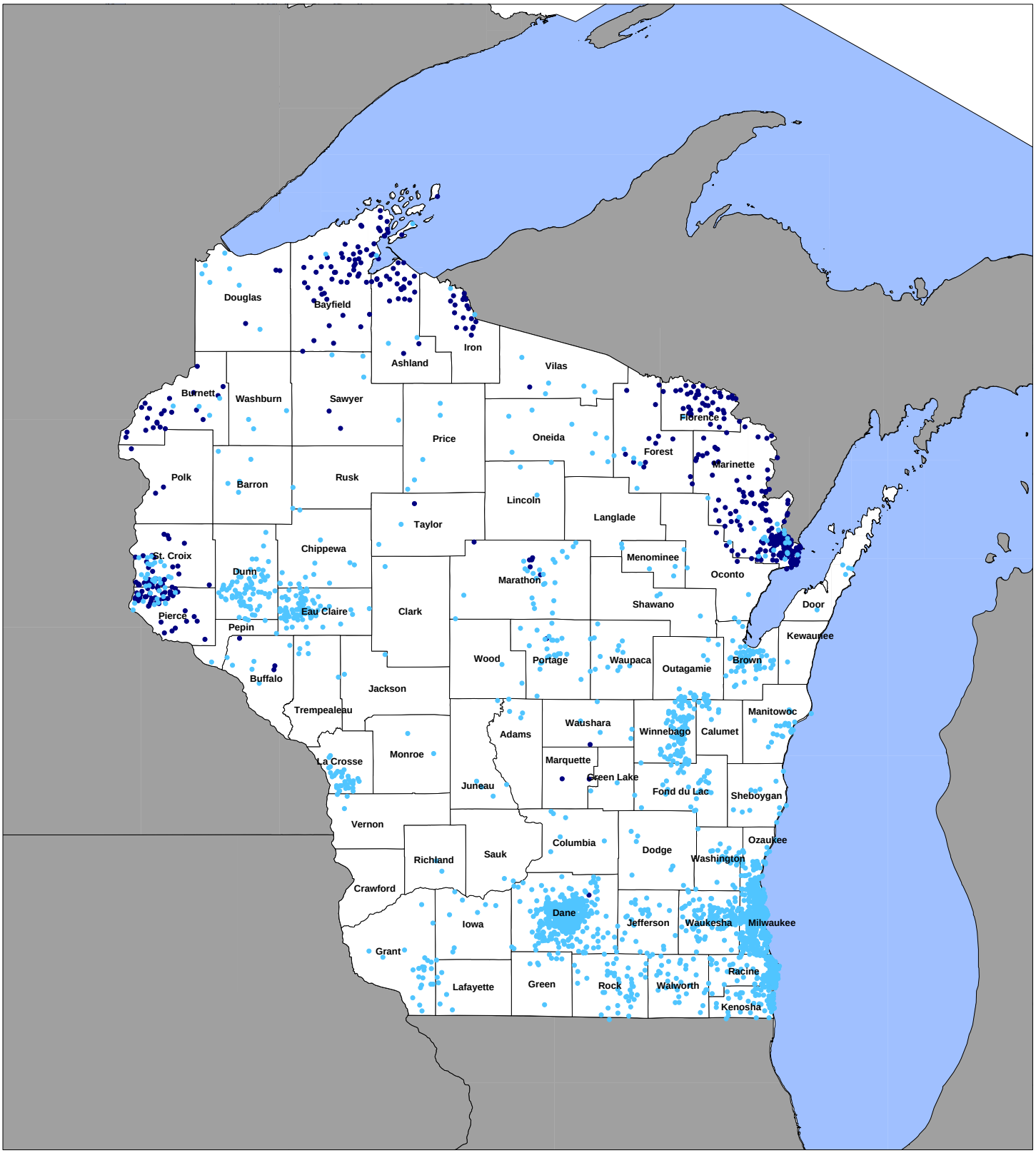
75.9% of the **Standard Plan** participants live within Wisconsin. Much of the Standard Plan population is located near larger metropolitan areas in Wisconsin with 25.4% of the population living in Dane County and 17.4% living in Milwaukee County.

The **SMP Plan** membership in comparison is almost entirely within Wisconsin. Of that population, the membership tends to reside in the more rural areas with a majority of the population on the northern fringes of the state. 52.0% of the SMP Plan participants live in 2 counties, Marinette and Pierce. In 2007 the SMP Plan region was reduced from 27 counties down to 12. In 2008, the SMP Plan region has been reduced by 3 more counties, removing Ashland, Marinette, and Pierce from the plan offering.

STATE EMPLOYEE TRUST FUNDS

Exhibit 4-A

Enrollment By County
December 2007



Standard

SMP

STATE EMPLOYEE TRUST FUNDS

Enrollment By County

December 2007

Exhibit 4-B

County	STANDARD # of Members	STANDARD % of Members	SMP # of Members	SMP % of Members
ADAMS	0	0.0%	0	0.0%
ASHLAND	3	0.1%	37	7.1%
BARRON	8	0.2%	0	0.0%
BAYFIELD	2	0.1%	50	9.6%
BROWN	56	1.4%	0	0.0%
BUFFALO	8	0.2%	2	0.4%
BURNETT	4	0.1%	23	4.4%
CALUMET	15	0.4%	0	0.0%
CHIPPEWA	9	0.2%	0	0.0%
CLARK	3	0.1%	0	0.0%
COLUMBIA	6	0.2%	0	0.0%
CRAWFORD	0	0.0%	0	0.0%
DANE	998	25.4%	1	0.2%
DODGE	7	0.2%	0	0.0%
DOOR	5	0.1%	0	0.0%
DOUGLAS	7	0.2%	4	0.8%
DUNN	76	1.9%	0	0.0%
EAU CLAIRE	89	2.3%	0	0.0%
FLORENCE	1	0.0%	36	6.9%
FOND DU LAC	29	0.7%	0	0.0%
FOREST	4	0.1%	15	2.9%
GRANT	28	0.7%	0	0.0%
GREEN	5	0.1%	0	0.0%
GREEN LAKE	6	0.2%	0	0.0%
IOWA	8	0.2%	0	0.0%
IRON	2	0.1%	18	3.5%
JACKSON	1	0.0%	0	0.0%
JEFFERSON	21	0.5%	0	0.0%
JUNEAU	4	0.1%	0	0.0%
KENOSHA	44	1.1%	0	0.0%
KEWAUNEE	1	0.0%	0	0.0%
LACROSSE	37	0.9%	0	0.0%
LAFAYETTE	1	0.0%	0	0.0%
LANGLADE	2	0.1%	0	0.0%
LINCOLN	3	0.1%	0	0.0%
MANITOWOC	21	0.5%	0	0.0%
MARATHON	21	0.5%	11	2.1%
MARINETTE	20	0.5%	200	38.5%
MARQUETTE	0	0.0%	3	0.6%
MENOMINEE	5	0.1%	0	0.0%
MILWAUKEE	681	17.4%	0	0.0%
MONROE	2	0.1%	0	0.0%
OCONTO	5	0.1%	0	0.0%
ONEIDA	9	0.2%	0	0.0%
OUTAGAMIE	19	0.5%	0	0.0%
OZAUKEE	66	1.7%	0	0.0%
PEPIN	2	0.1%	1	0.2%
PIERCE	23	0.6%	70	13.5%
POLK	0	0.0%	2	0.4%
PORTAGE	24	0.6%	1	0.2%
PRICE	5	0.1%	0	0.0%
RACINE	152	3.9%	4	0.8%
RICHLAND	2	0.1%	0	0.0%
ROCK	42	1.1%	0	0.0%
RUSK	0	0.0%	0	0.0%
SAUK	9	0.2%	0	0.0%
SAWYER	5	0.1%	2	0.4%
SHAWANO	3	0.1%	0	0.0%
SHEBOYGAN	13	0.3%	0	0.0%
ST CROIX	13	0.3%	15	2.9%
TAYLOR	1	0.0%	2	0.4%
TREMPEALEAU	3	0.1%	0	0.0%
VERNON	2	0.1%	0	0.0%
VILAS	5	0.1%	1	0.2%
WALWORTH	36	0.9%	0	0.0%
WASHBURN	2	0.1%	0	0.0%
WASHINGTON	29	0.7%	0	0.0%
WAUKESHA	129	3.3%	0	0.0%
WAUPACA	13	0.3%	0	0.0%
WAUSHARA	2	0.1%	0	0.0%
WINNEBAGO	111	2.8%	0	0.0%
WOOD	10	0.3%	0	0.0%
OUT OF STATE	944	24.1%	21	4.0%
Totals	**3,922**	**100.0%**	**519**	**100.0%**

Out of State Enrollment

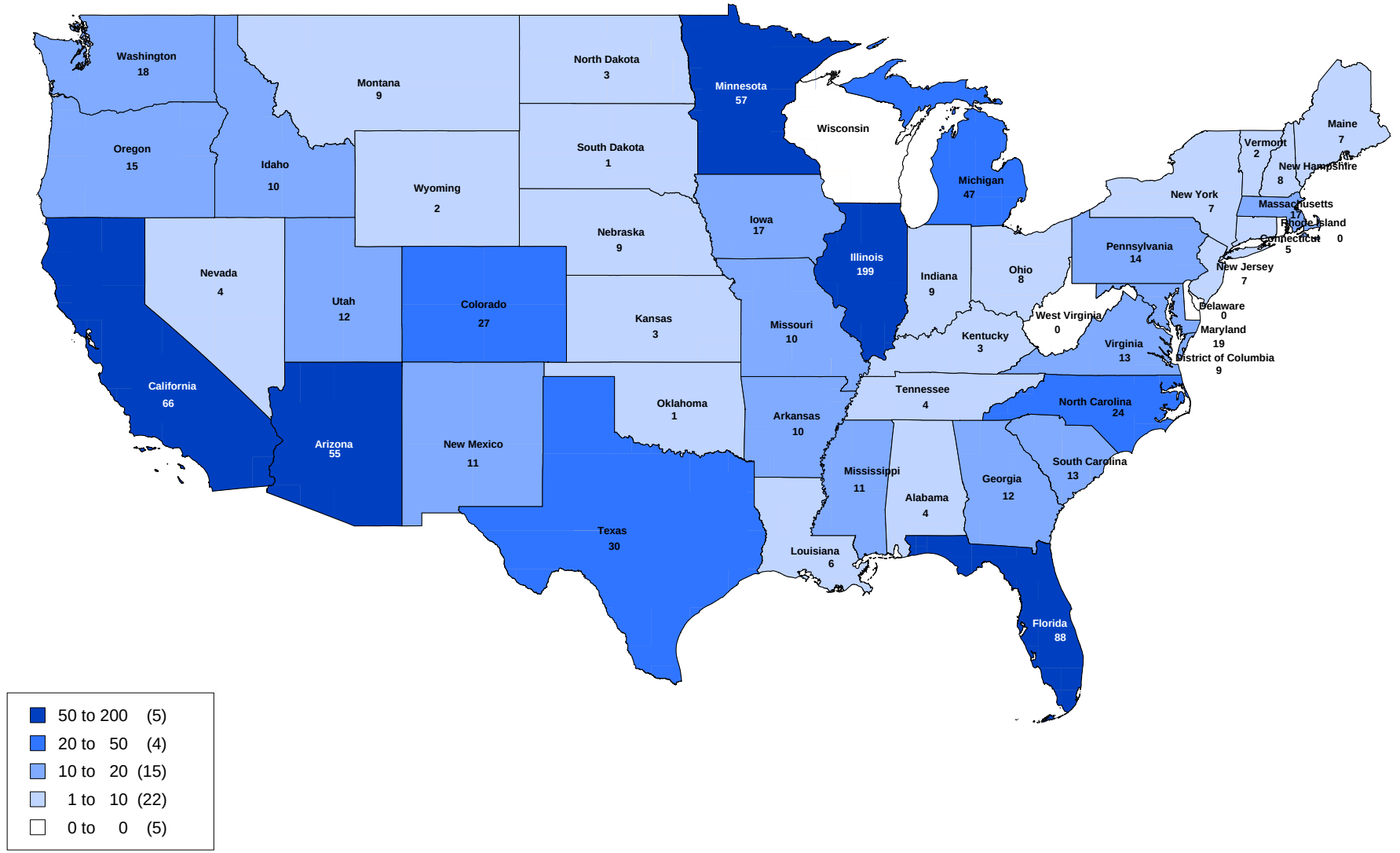
The United States Enrollment Map in Exhibit 5-A visually depicts how the enrollment in the Standard and SMP Plans are spread throughout the United States. The out of state enrollment is based on the member's address as of December 2007 and could change as members relocate. The map displays the number of Standard and SMP Plan members living in each state along with a shading scheme in which higher population areas are represented with increasingly darker shading. Exhibit 5-B shows the same information numerically.

The **Standard Plan** has 24.1% of the population living outside the state of Wisconsin with the membership dispersed over 46 states with an additional 55 members living internationally. 31.9% of the out of state enrollment lives along the Wisconsin border with the largest number of members living in Illinois (199 members or 21.1%). Another area of membership concentration is in typical retirement states with 25.2% of the out of state membership residing in Florida (88), California (66), Arizona (54) and Texas (30).

The **SMP Plan** in comparison has only 4.0% of the population living outside the state of Wisconsin. A majority of the out of state membership resides in Minnesota and Michigan. These individuals are likely employees living on the Wisconsin border. The SMP Plan does have some provider coverage in the states bordering Wisconsin however the plan does not have any non-emergency provider coverage in other states.

STATE EMPLOYEE TRUST FUNDS
Out of State Enrollment
December 2007

Exhibit 5-A



STATE EMPLOYEE TRUST FUNDS

Out of State Enrollment

December 2007

Exhibit 5-B

State	STANDARD # of Members	STANDARD % of Members	SMP # of Members	SMP % of Members
ALABAMA	4	0.4%	0	0.0%
ALASKA	0	0.0%	0	0.0%
ARIZONA	54	5.7%	1	4.8%
ARKANSAS	10	1.1%	0	0.0%
CALIFORNIA	66	7.0%	0	0.0%
COLORADO	27	2.9%	0	0.0%
CONNECTICUT	5	0.5%	0	0.0%
DELAWARE	0	0.0%	0	0.0%
FLORIDA	88	9.3%	0	0.0%
GEORGIA	12	1.3%	0	0.0%
HAWAII	3	0.3%	0	0.0%
IDAHO	10	1.1%	0	0.0%
ILLINOIS	199	21.1%	0	0.0%
INDIANA	9	1.0%	0	0.0%
IOWA	17	1.8%	0	0.0%
KANSAS	3	0.3%	0	0.0%
KENTUCKY	3	0.3%	0	0.0%
LOUISIANA	6	0.6%	0	0.0%
MAINE	7	0.7%	0	0.0%
MARYLAND	19	2.0%	0	0.0%
MASSACHUSETTS	17	1.8%	0	0.0%
MICHIGAN	30	3.2%	17	81.0%
MINNESOTA	55	5.8%	2	9.5%
MISSISSIPPI	11	1.2%	0	0.0%
MISSOURI	10	1.1%	0	0.0%
MONTANA	9	1.0%	0	0.0%
NEBRASKA	9	1.0%	0	0.0%
NEVADA	4	0.4%	0	0.0%
NEW HAMPSHIRE	8	0.8%	0	0.0%
NEW JERSEY	7	0.7%	0	0.0%
NEW MEXICO	11	1.2%	0	0.0%
NEW YORK	7	0.7%	0	0.0%
NORTH CAROLINA	24	2.5%	0	0.0%
NORTH DAKOTA	3	0.3%	0	0.0%
OHIO	8	0.8%	0	0.0%
OKLAHOMA	1	0.1%	0	0.0%
OREGON	15	1.6%	0	0.0%
PENNSYLVANIA	14	1.5%	0	0.0%
RHODE ISLAND	0	0.0%	0	0.0%
SOUTH CAROLINA	13	1.4%	0	0.0%
SOUTH DAKOTA	1	0.1%	0	0.0%
TENNESSEE	4	0.4%	0	0.0%
TEXAS	30	3.2%	0	0.0%
UTAH	12	1.3%	0	0.0%
VERMONT	2	0.2%	0	0.0%
VIRGINIA	13	1.4%	0	0.0%
WASHINGTON	18	1.9%	0	0.0%
WASHINGTON DC	9	1.0%	0	0.0%
WEST VIRGINIA	0	0.0%	0	0.0%
WYOMING	2	0.2%	0	0.0%
FOREIGN	55	5.8%	1	4.8%
Totals	**944**	**100.0%**	**21**	**100.0%**

Dual Choice Changes

The Dual Choice Enrollment Changes by Plan report in Exhibit 6-A shows the January 2008 enrollment reflecting changes that occurred during the Dual Choice Enrollment. The enrollment changes are numerical differences relative to December 2007. The change in Member / Age Gender shows how much plan costs changed between 2007 and 2008 due to demographic factors. The age/gender factor is not shown for the Medicare Plus $1M Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

Exhibit 6-A shows total enrollment for all plans was 13,957 members as of January 2008, which is down 198 members from the 14,155 members in the plan in December 2007. The reduction in membership was mainly due to the loss of members in the SMP Plan related to new HMO offerings in Ashland, Marinette, and Pierce counties. The Standard Plan also experienced the loss of 12 members during Dual Choice Enrollment. The Medicare Plus $1M membership actually increased by 172 individuals in January 2008. The positive change in age/gender factors for the Standard and SMP Plans means both got more expensive demographically in 2008 on a per member basis as a result of the membership loss and overall aging of the population.

Exhibit 6-A

STATE EMPLOYEE TRUST FUNDS
Dual Choice Enrollment Changes by Plan
December 2007 to January 2008

Plan	Class	January 2008 Membership	Change in Membership from December 2007	Change in Member Age/ Gender
Standard	Regular	2,806	-10	1.78%
	Graduate Assistant (including GA continuation)	372	-15	1.57%
	Continuation	29	9	-10.29%
	Annuitants	703	4	1.59%
	Subtotal	**3,910**	**-12**	**1.81%**
SMP	Regular	125	-345	-0.40%
	Graduate Assistant (including GA continuation)	3	-1	-8.72%
	Continuation	1	0	0.00%
	Annuitants	32	-12	1.79%
	Subtotal	**161**	**-358**	**8.04%**
Medicare Plus One Million	Single	4,599	50	N/A
	One Over	254	9	N/A
	Two Over	5,033	113	N/A
	Subtotal	**9,886**	**172**	**N/A**
ETF Grand Total		**13,957**	**-198**	**N/A**

Paid Per Member Per Month Costs

The Paid Medical and Drug PMPM report in Exhibit 7-A displays the average amount paid per member each month for the Standard, SMP and Medicare Plus $1M Plans incurred from January 2006 through December 2007. The PMPM costs for each plan represent medical and drug claims paid through the end of March 2008.

Standard Plan

The Standard Plan has seen an 8.3% increase in claim costs between 2006 and 2007. Independent trend estimates for medical claims for 2007 were 9-11% thus the Standard Plan ran slightly better than expected. The monthly spikes in claim costs are generally due to large claim activity that occurred in those months.

In 2007, the Standard plan was 87.9% higher in overall claims costs on a PMPM basis when compared to the SMP Plan. The Standard Plan's enrollment is generally in more expensive urban areas such as Milwaukee and Dane Counties. A bigger factor is the difference in demographics between the two plans, which by itself would be expected to raise the Standard Plan's costs another 26.0% above the SMP Plan. The small size of the SMP Plan compared to the larger Standard Plan, along with the dramatic reduction in SMP plan membership in 2007, adds to the variability of the results. The final piece is simply the anti-selection that the Standard Plan is subject to versus the other options available to the membership. Members who utilize healthcare services are generally willing to make a larger premium contribution and incur modest cost sharing provisions within the benefit plan in exchange for the broader panel of providers.

SMP Plan

The SMP Plan saw a dramatic drop in membership in 2007, therefore year over year trend numbers have less meaning. However, for informational purposes, the SMP plan saw a 1.8% decrease in claims costs between 2006 and 2007.

Medicare

The Medicare Plus $1M Plan has seen stable results over the last 2 years. We would expect this population to have stable results since Medicare is the primary payer and the plan has a large population. Seasonally, the medical only costs start out high during the first months of the year and then decline. When drug costs are added, the pattern is reversed and more resembles a typical non-Medicare plan. The

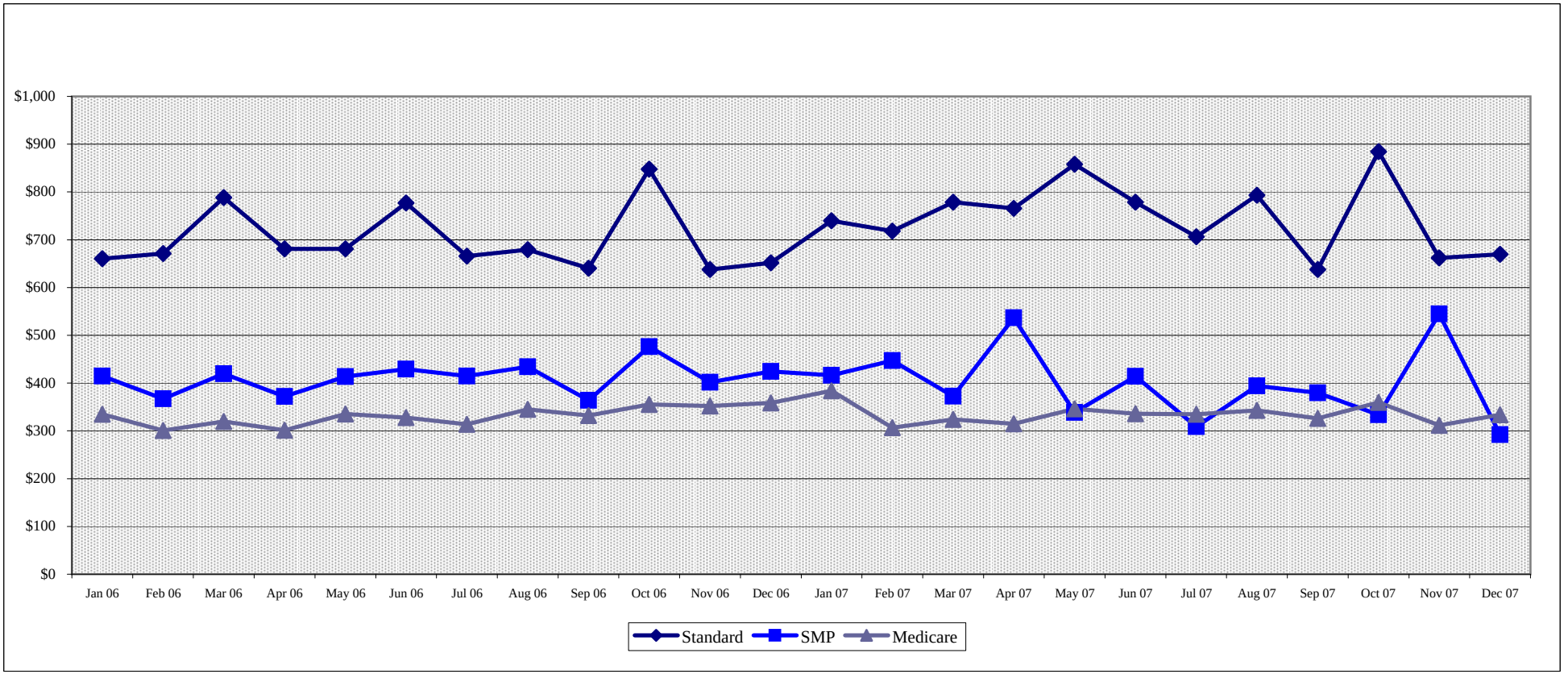
year over year medical PMPM trend from 2006 to 2007 was 7.3%, which is in line with WPS's Medicare supplement trend. We would naturally expect a small increase in the medical claims each year due to the benefit changes Medicare makes annually and medical cost trend.

STATE EMPLOYEE TRUST FUNDS

Paid Medical and Drug PMPM

Paid Through March 2008

Exhibit 7-A



	INCURRED MONTH																							
	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
Standard	$660.51	$671.30	$788.43	$681.14	$680.67	$776.77	$665.58	$679.08	$640.31	$847.55	$637.56	$651.68	$739.61	$718.09	$778.80	$765.89	$857.84	$778.54	$706.32	$793.33	$637.75	$884.60	$661.87	$669.57
SMP	$414.73	$366.98	$419.59	$371.77	$413.53	$429.38	$414.60	$434.01	$364.07	$476.49	$401.80	$424.47	$416.19	$447.31	$372.81	$536.77	$338.76	$414.05	$308.68	$394.17	$379.56	$333.79	$544.81	$292.13
Medicare	$334.68	$300.76	$319.88	$301.17	$335.05	$327.66	$313.65	$344.97	$332.17	$355.33	$352.21	$358.70	$383.87	$306.54	$323.96	$314.70	$345.95	$335.98	$334.99	$342.91	$326.34	$359.84	$311.74	$333.58

PMPM by Type of Service

The Total PMPM by Type of Service reports (8-A and 8-C) provide a breakdown of the PMPM by major type of service compared to the benchmark. The pie chart also provides an overview of the percentage of the PMPM each major type of service is contributing to the total PMPM plus a comparison to the benchmark. The actual PMPM costs are for claims incurred January 2007 – December 2007 and paid through the end of March 2008. The Paid PMPM by Type of Service reports (8-B, 8-D, and 8-E) show the same actual data, but compare 2006 to 2007.

Standard Plan

The Standard Plan in Exhibit 8-A shows that the percentage breakdown by major type of service is similar to the benchmark with a slightly smaller percentage falling into the physician category and a little more falling into the outpatient physician and other services categories.

The bottom chart in Exhibit 8-A shows that the total PMPM cost is 47.9% above the benchmark. The inpatient facility PMPM cost is 53.0% above the benchmark and outpatient facility is 68.0% above the benchmark. The physician PMPM cost is 21.4% above the benchmark. The drug paid PMPM cost is 45.7% above the benchmark and roughly in line with the variance of the non-drug paid costs. Lastly the other services category is 87.6% over the norm. The largest contributor to this differential is the psychiatric/AODA benefit sub-category which is $22.47 above the norm. Every $1.00 PMPM represented in the graph is equivalent to $46,800 in annual plan costs for the Standard Plan.

Exhibit 8-B compares the Standard Plan's paid PMPM costs for 2006 vs. 2007, showing an 8.3% increase between the two years. Facility outpatient costs on a PMPM basis increased by 24.3% between the two years. The other services category actually decreased by 10.3%. The remaining categories increased near expected levels

SMP Plan

Exhibit 8-C shows the percentage breakdown by type of service for the SMP Plan is fairly close to the benchmark, with slightly more services falling into the facility outpatient category.

In total the SMP Plan is at the benchmark, with the plan being under in the facility inpatient, drug and other services categories. Facility outpatient is the biggest deviation from the benchmark, being 17.4% higher than our norms.

Exhibit 8-D compares the SMP Plan's paid PMPM costs for 2006 vs. 2007. Facility inpatient and facility outpatient costs increased by 23.5% and 34.8% while the rest of the categories were significantly lower in 2007. The total PMPM decreased by 1.8% in 2007. Due to the dramatic change in membership that occurred in 2007, we would expect this degree of variability.

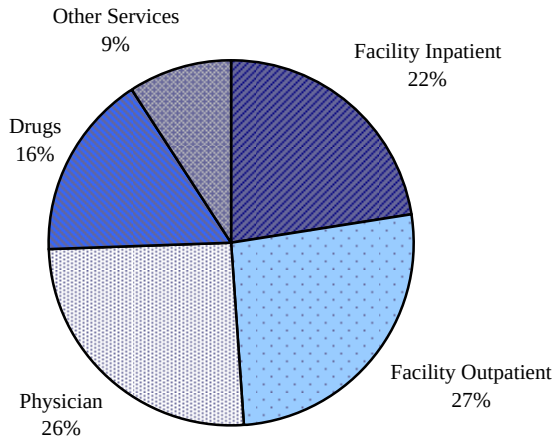
Medicare

The Medicare Plus $1M Plan in Exhibit 8-E compares paid PMPM costs for 2006 vs. 2007. The medical segment of the paid PMPM cost accounts for only 38.3% of the payments made under the plan due to the impact of coordination of benefits with Medicare. In total the PMPM increased by 2% in 2007. Prescription drugs decreased by 1% while the medical categories experienced single digit increases, averaging 7.3%.

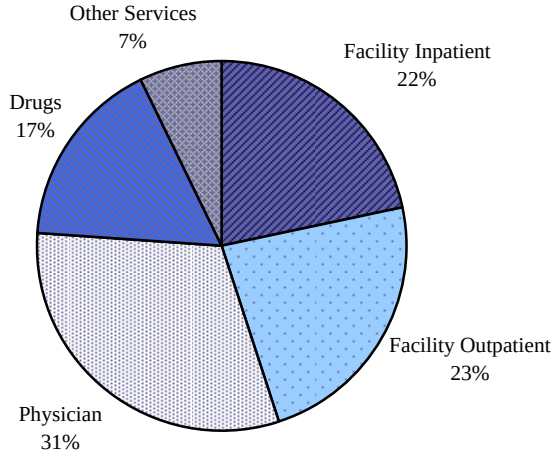
Exhibit 8-A

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Standard
Incurred January 2007 - December 2007 Paid Through March 2008

Actual PMPM



Benchmark PMPM



			Difference	
	Actual	Benchmark	$	%
Facility Inpatient	**$168.49**	**$110.14**	**$58.35**	**53.0%**
Facility Outpatient	**$197.08**	**$117.31**	**$79.77**	**68.0%**
Physician	**$192.35**	**$158.42**	**$33.93**	**21.4%**
Drugs	**$123.02**	**$84.44**	**$38.58**	**45.7%**
Other Services	**$68.28**	**$36.39**	**$31.89**	**87.6%**
Totals	**$749.22**	**$506.70**	**$242.52**	**47.9%**

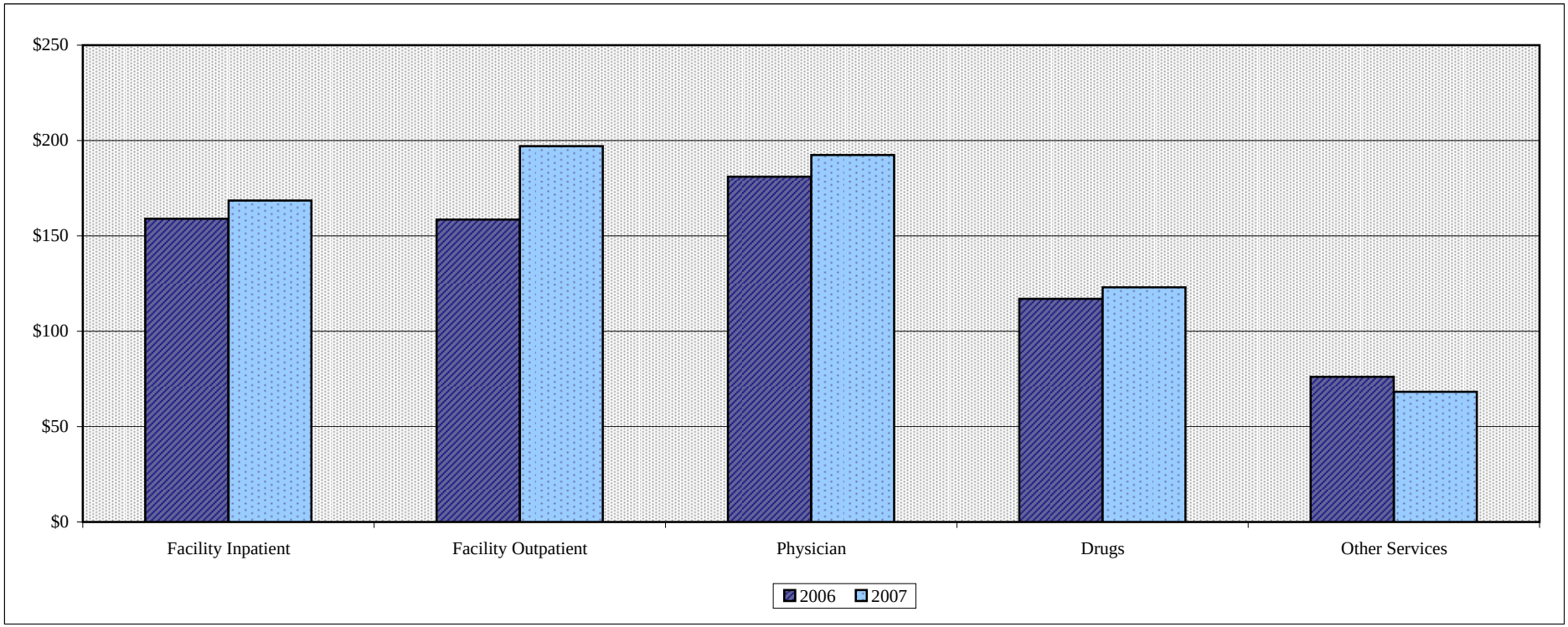
Note: Drug includes prescription and injectables

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

*** Each $1.00 paid PMPM = $46,800 in plan costs.**

Exhibit 8-B

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Standard
Comparison of 2007 to 2006



			Difference	
	2006 *	2007 **	$	%
Facility Inpatient	$158.97	$168.49	$9.52	6.0%
Facility Outpatient	$158.61	$197.08	$38.47	24.3%
Physician	$181.10	$192.35	$11.25	6.2%
Drugs	$116.99	$123.02	$6.03	5.2%
Other Services	$76.09	$68.28	-$7.81	-10.3%
Totals	$691.76	$749.22	$57.46	8.3%

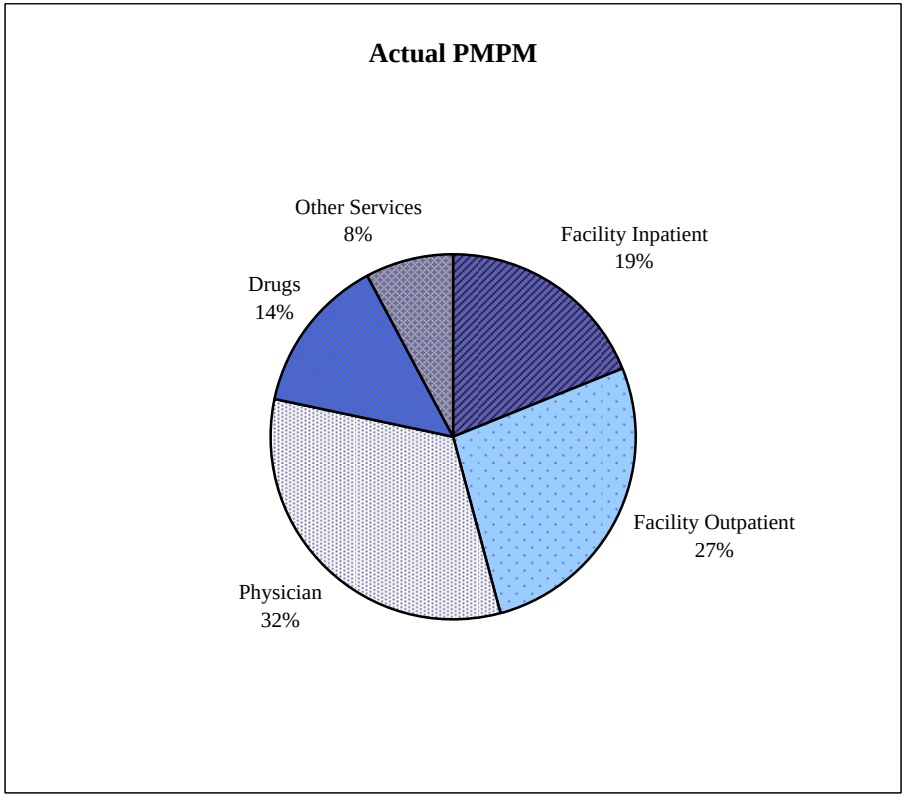
Note: Drug includes prescription and injectables

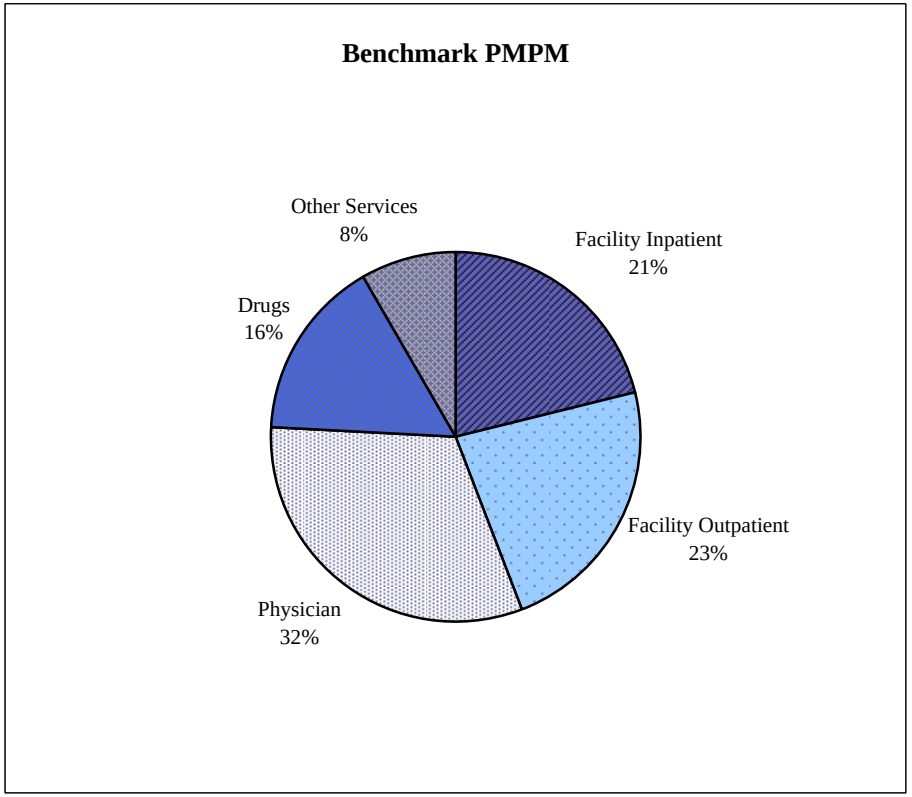
*** Each $1.00 paid PMPM = $52,016 in plan costs.**

**** Each $1.00 paid PMPM = $46,800 in plan costs.**

Exhibit 8-C

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - SMP
Incurred January 2007 - December 2007 Paid Through March 2008





			Difference	
	Actual	Benchmark	$	%
Facility Inpatient	**$75.07**	**$83.55**	**-$8.48**	**-10.1%**
Facility Outpatient	**$107.94**	**$91.92**	**$16.02**	**17.4%**
Physician	**$129.05**	**$125.21**	**$3.84**	**3.1%**
Drugs	**$55.67**	**$62.69**	**-$7.02**	**-11.2%**
Other Services	**$31.01**	**$33.24**	**-$2.23**	**-6.7%**
Totals	**$398.74**	**$396.61**	**$2.13**	**0.5%**

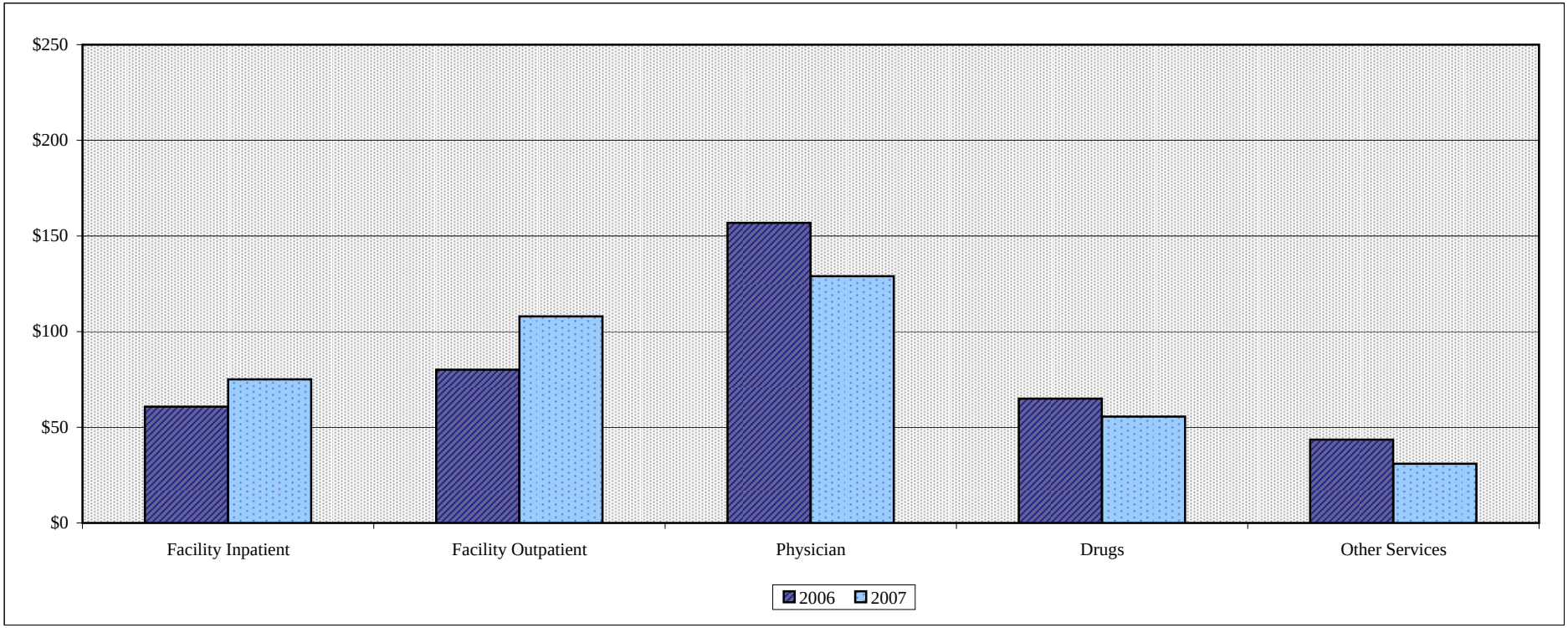
Note: Drug includes prescription and injectables

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

*** Each $1.00 paid PMPM = $6,392 in plan costs.**

Exhibit 8-D

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - SMP
Comparison of 2007 to 2006



			Difference	
	2006 *	2007 **	$	%
Facility Inpatient	$60.79	$75.07	$14.28	23.5%
Facility Outpatient	$80.05	$107.94	$27.89	34.8%
Physician	$156.88	$129.05	-$27.83	-17.7%
Drugs	$64.99	$55.67	-$9.32	-14.3%
Other Services	$43.50	$31.01	-$12.49	-28.7%
Totals	$406.21	$398.74	-$7.47	-1.8%

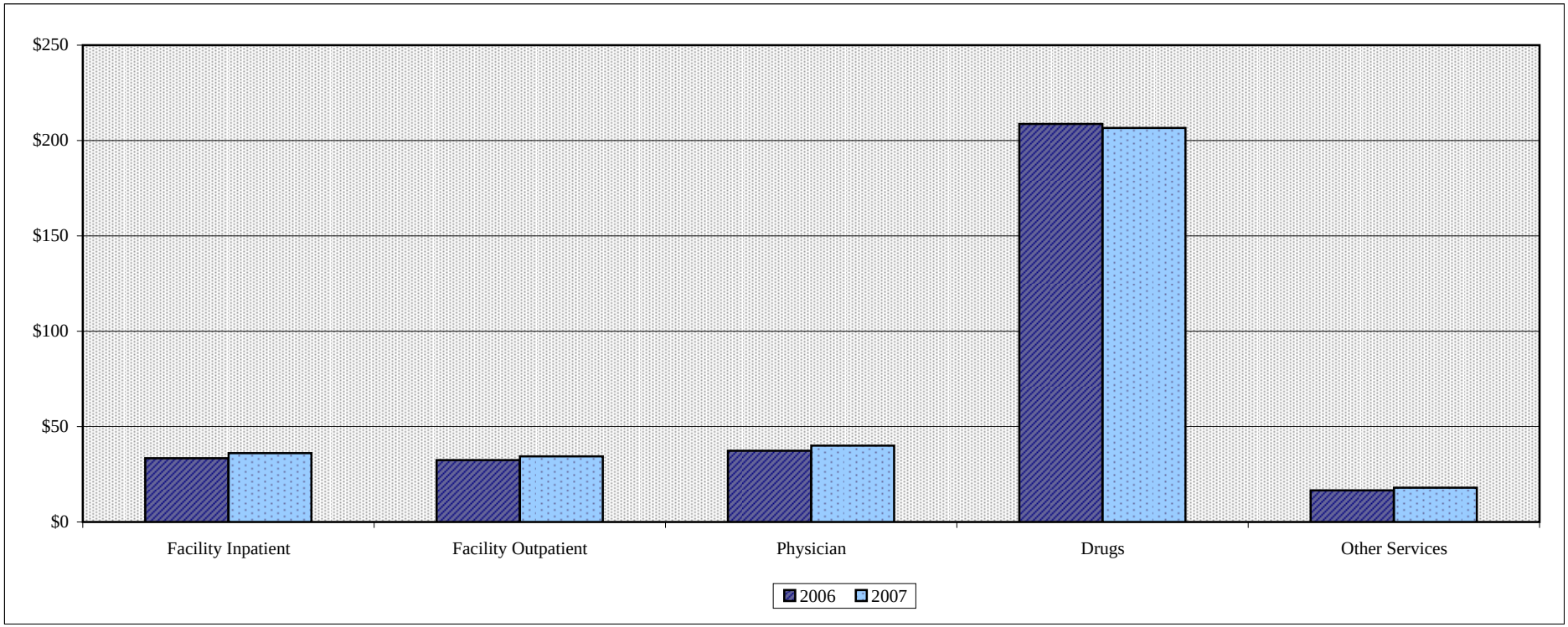
Note: Drug includes prescription and injectables

*** Each $1.00 paid PMPM = $97,961 in plan costs.**

**** Each $1.00 paid PMPM = $6,392 in plan costs.**

Exhibit 8-E

STATE EMPLOYEE TRUST FUNDS
Total PMPM by Type of Service - Medicare Plus One Million
Comparison of 2007 to 2006



			Difference	
	2006 *	2007 **	$	%
Facility Inpatient	$33.47	$36.05	$2.58	7.7%
Facility Outpatient	$32.50	$34.43	$1.93	6.0%
Physician	$37.32	$40.09	$2.77	7.4%
Drugs	$208.72	$206.58	-$2.14	-1.0%
Other Services	$16.51	$17.92	$1.41	8.5%
Totals	$328.51	$335.07	$6.56	2.0%

Note: Drug includes prescription and injectables

*** Each $1.00 paid PMPM = $120,917 in plan costs.**

**** Each $1.00 paid PMPM = $117,541 in plan costs.**

Type of Service Detail

The Type of Service Detail report provides an overview of paid medical costs on a PMPM basis divided into 5 major service categories and further divided into 26 subcategories. The Actual PMPM costs are compared to the benchmark PMPM to help determine where the plan is experiencing higher than normal claim costs. The comparison to the benchmark is displayed as a PMPM difference and as a percentage difference. The Actual PMPM cost are for claims incurred January 2007 – December 2007 and paid through the end of March 2008.

Standard Plan

The Standard Plan in Exhibit 9-A was 47.9% above the benchmark in 2007. The variance to the benchmark is primarily a result of the anti-selection resulting from the dual choice open enrollment. Other contributing factors include the location of the Standard Plan's enrolled membership (the higher cost urban areas) and the rich benefit design. Since the percentage comparison can be deceiving, it is more important to look at the PMPM difference with $1.00 PMPM being equivalent to $46,800 in annual plan costs. Below are some areas that stand out relative to the benchmark and some analysis on what is driving the higher costs:

- Facility Inpatient – The majority of dollars are for surgical/medical services. Within surgical/medical, $10.05 PMPM is due to gastric bypass procedures not generally included in the norm. Another contributor to the overage is higher than expected large claim activity. For those claimants over $100,000, 48.1% of their claims fall into the inpatient facility category and drive a higher than expected PMPM. Also, psych/AODA services were 498.1% above the norm. In the psych/AODA category, $6.50 PMPM is due to a single large claimant.

- Facility Outpatient – Higher than expected costs in this category are reflective of the relative morbidity of the Standard Plan's population. Greater use of diagnostic services such as CT scans, MRIs and lab work has lead to cost variances versus the norm for outpatient radiology and pathology services. Costs in the other services category are 95.5% above the norm and 34.4% higher than last year. This difference is due to a significant change in the case mix of the high cost claimants who used more services such as chemotherapy. Psych/AODA services are still well above the norm but the PMPM has decreased from 2006 to 2007.

- Physician – The surgery category is $12.17 PMPM above the benchmark. Gastric bypass procedures have added $5.02 to the Paid PMPM cost. Costs for these procedures are not generally accounted for in the benchmark.

- Drug – The prescription drug and injectable costs are higher than the benchmark, however they are in line with the plan's performance overall. The injectable drug category warrants special attention into the future. Specialty drugs can have exceptionally high mark-ups when provided in a physician's office. Certain drugs are often less costly to the plan if provided through the PBM. Select drugs can be self-injected by the patient in their own home, which is often viewed positively by the member. Taking a proactive approach, contract/benefit language should be reviewed so specialty drugs can be most effectively managed in the future.

- Other services – The other services category is $31.89 above the benchmark. The major contributor to the variance is the Psychiatric /AODA cost which is $22.47 PMPM above the benchmark. The Standard Plan's benefit design in this sub-category is more comprehensive than the typical commercial plan, which is often limited to the Wisconsin state mandate.

SMP Plan

The SMP Plan in Exhibit 9-B by comparison is in line with the benchmark for 2007. For the plan $1.00 PMPM represented in the chart is equivalent to $6,392 in annual plan costs.

- Inpatient Facility – This category is running better than the benchmark. However, maternity costs are actually $4.93 higher than expected, driven by a slightly higher than expected incidence rate.

- Outpatient Facility –- On a dollar basis, the Surgical/Medical, Radiology, Psych/AODA, and Other categories are running well above the norm. High therapy and blood costs led to the overage in the outpatient-other category.

- Physician – This category is running close to expected. The Office Visit, Maternity and Other sub-categories are all well above the norm.

- Drug – The prescription drug PMPM cost is running 27.3% below the norm, while injectable drug costs are running 110.2% above the norm. Injectable drugs are high cost, low frequency events which warrant special attention. With the smaller SMP population, if someone requires these types of claims, one individual can drive the costs above the norm.

- Other Services – The Chiropractic sub-category is $1.37 above the norm which is a function of the region in which the SMP population resides. In the northern region, chiropractic care is more commonly used to treat back problems in comparison to other areas of the state. The other sub-category is $1.48 PMPM above the norm and appears to be driven by higher than expected costs for immunizations and hearing exams. Well baby exams are higher than expected with tends to be correlated with the higher maternity costs mentioned above.

Exhibit 9-A

STATE EMPLOYEE TRUST FUNDS

Type of Service Detail - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE $	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	$153.02	$102.99	$50.03	48.6%
	PSYCH/AODA	$9.51	$1.59	$7.92	498.1%
	MATERNITY	$3.52	$4.36	-$0.84	-19.3%
	OTHER	$2.44	$1.20	$1.24	103.3%
	Subtotal	**$168.49**	**$110.14**	**$58.35**	**53.0%**
FACILITY OUTPATIENT	SURGICAL/MEDICAL	$29.98	$22.01	$7.97	36.2%
	RADIOLOGY	$49.12	$33.05	$16.07	48.6%
	PATHOLOGY	$23.47	$13.16	$10.31	78.3%
	EMERGENCY ROOM	$5.84	$3.80	$2.04	53.7%
	PSYCH/AODA	$2.02	$0.96	$1.06	110.4%
	OTHER	$86.65	$44.33	$42.32	95.5%
	Subtotal	**$197.08**	**$117.31**	**$79.77**	**68.0%**
PHYSICIAN	OFFICE VISIT	$25.87	$20.37	$5.50	27.0%
	RADIOLOGY	$34.56	$29.96	$4.60	15.4%
	PATHOLOGY	$23.73	$18.76	$4.97	26.5%
	SURGERY	$61.03	$48.86	$12.17	24.9%
	ANESTHESIA	$10.96	$9.86	$1.10	11.2%
	MATERNITY	$1.32	$2.26	-$0.94	-41.6%
	OTHER	$34.88	$28.35	$6.53	23.0%
	Subtotal	**$192.35**	**$158.42**	**$33.93**	**21.4%**
DRUGS	PRESCRIPTIONS	$107.62	$74.57	$33.05	44.3%
	INJECTABLES	$15.40	$9.87	$5.53	56.0%
	Subtotal	**$123.02**	**$84.44**	**$38.58**	**45.7%**
OTHER SERVICES	PSYCH/AODA	$27.86	$5.39	$22.47	416.9%
	CHIROPRACTIC	$4.13	$3.30	$0.83	25.2%
	THERAPIES	$8.85	$3.74	$5.11	136.6%
	AMBULANCE	$1.96	$1.86	$0.10	5.4%
	WELL BABY EXAM	$0.32	$0.31	$0.01	3.2%
	DURABLE MEDICAL EQUIPMENT	$8.62	$5.55	$3.07	55.3%
	OTHER	$16.54	$16.24	$0.30	1.8%
	Subtotal	**$68.28**	**$36.39**	**$31.89**	**87.6%**
Grand Total		**$749.22**	**$506.70**	**$242.52**	**47.9%**

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

*** Each $1.00 paid PMPM = $46,800 in plan costs.**

Exhibit 9-B

STATE EMPLOYEE TRUST FUNDS

Type of Service Detail - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE $	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	$64.44	$75.93	-$11.49	-15.1%
	PSYCH/AODA	$0.43	$1.61	-$1.18	-73.3%
	MATERNITY	$10.15	$5.22	$4.93	94.4%
	OTHER	$0.05	$0.79	-$0.74	-93.7%
	Subtotal	**$75.07**	**$83.55**	**-$8.48**	**-10.1%**
FACILITY OUTPATIENT	SURGICAL/MEDICAL	$20.43	$17.43	$3.00	17.2%
	RADIOLOGY	$28.21	$25.21	$3.00	11.9%
	PATHOLOGY	$11.28	$10.04	$1.24	12.4%
	EMERGENCY ROOM	$3.74	$3.45	$0.29	8.4%
	PSYCH/AODA	$3.50	$1.05	$2.45	233.3%
	OTHER	$40.78	$34.74	$6.04	17.4%
	Subtotal	**$107.94**	**$91.92**	**$16.02**	**17.4%**
PHYSICIAN	OFFICE VISIT	$18.35	$16.70	$1.65	9.9%
	RADIOLOGY	$19.39	$22.63	-$3.24	-14.3%
	PATHOLOGY	$15.90	$15.05	$0.85	5.6%
	SURGERY	$36.03	$37.93	-$1.90	-5.0%
	ANESTHESIA	$8.35	$7.77	$0.58	7.5%
	MATERNITY	$5.41	$2.69	$2.72	101.1%
	OTHER	$25.62	$22.44	$3.18	14.2%
	Subtotal	**$129.05**	**$125.21**	**$3.84**	**3.1%**
DRUGS	PRESCRIPTIONS	$40.26	$55.36	-$15.10	-27.3%
	INJECTABLES	$15.41	$7.33	$8.08	110.2%
	Subtotal	**$55.67**	**$62.69**	**-$7.02**	**-11.2%**
OTHER SERVICES	PSYCH/AODA	$2.02	$5.87	-$3.85	-65.6%
	CHIROPRACTIC	$4.36	$2.99	$1.37	45.8%
	THERAPIES	$3.38	$3.13	$0.25	8.0%
	AMBULANCE	$1.17	$1.45	-$0.28	-19.3%
	WELL BABY EXAM	$1.02	$0.79	$0.23	29.1%
	DURABLE MEDICAL EQUIPMENT	$2.88	$4.31	-$1.43	-33.2%
	OTHER	$16.18	$14.70	$1.48	10.1%
	Subtotal	**$31.01**	**$33.24**	**-$2.23**	**-6.7%**
Grand Total		**$398.74**	**$396.61**	**$2.13**	**0.5%**

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

*** Each $1.00 paid PMPM = $6,392 in plan costs.**

Inpatient Utilization, Days/1000 and Average Length of Stay

The Inpatient Utilization report compares annual inpatient days per 1,000, admits per 1,000, average length of stay, cost per day, cost per admit, and inpatient PMPM cost to the benchmark for the 5 major inpatient service categories. Days/1000 is the annual average number of hospital days utilized by a population of 1,000 members which is calculated by taking (Total Days/Member Months)*12000. The Admits/1000 is the annual number of admits that occur within a typical population of 1,000 members which is calculated by taking (Total Admits/Member Months)*12000. The Days/1000 and Admits/1000 are calculations that allow a comparison of one population to another regardless of group size. Average Length of Stay (ALOS) shows the average length of hospitalization experienced for the entire group (Total Days/Total Admits). Cost per Day is an average of the cost per hospital day (Total Cost/Total Days). The cost per admit is an average of the cost per hospital admission (Total Cost/Total Admits). Lastly the inpatient PMPM is the per member per month cost incurred by the plan. Beyond the numerical comparison, a percentage has been included as observed in the pie charts, including a comparison to the benchmark.

Standard Plan

The totals for the Standard Plan in Exhibit 10-A exceed the benchmark totals for all statistics. The Medical category is below the benchmark in Days/1000, Admits/1000, and ALOS. In contrast, the Surgical category is above the benchmark in Days/1000 and Admits/1000. Contributing factors to the variance include gastric bypass procedures that are not generally accounted for in the benchmark as well as higher than expected large claim activity. For claimants with annual claims over $100,000, 25.9% of their claims fall into the surgical inpatient hospital category. The other inpatient services category appears higher than expected. This is due to the reporting of admits for skilled nursing facility stays being counted in the medical or surgical categories when a stay is continuous.

SMP

No SMP report due to small size of block and lack of credibility.

Exhibit 10-A

STATE EMPLOYEE TRUST FUNDS

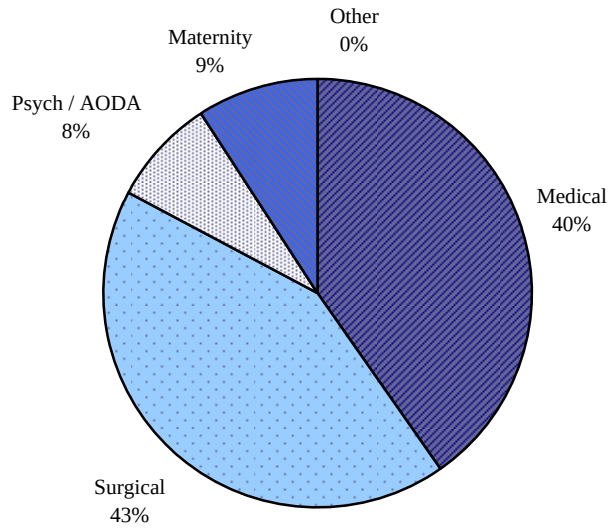
Inpatient Utilization - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

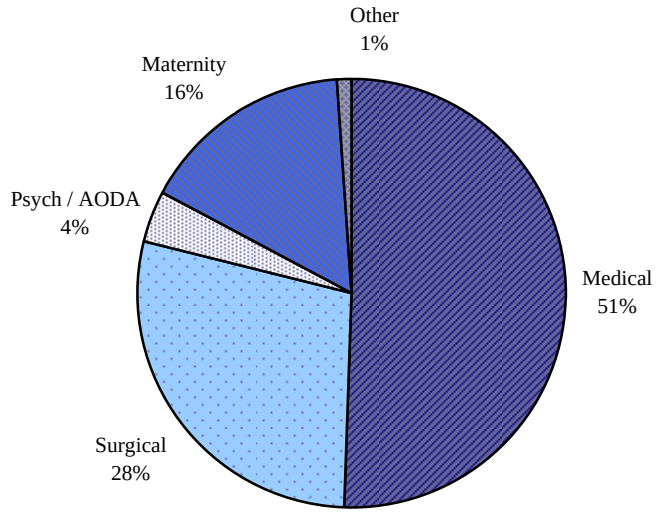
ACTUAL	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	155	179	36	22	63	455
Admits/1000	35	37	7	8	0	87
ALOS	4.38	4.86	5.26	2.55	247.00	5.18
Cost/Day	$3,787	$6,957	$3,134	$1,962	$463	$4,435
Cost/Admit	$16,603	$33,820	$16,483	$4,993	$114,296	$22,990
PMPM	$48.96	$104.07	$9.51	$3.52	$2.44	$168.50
% of Paid	29.06%	61.76%	5.64%	2.09%	1.45%	100.00%

BENCHMARK	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	187	108	19	32	55	401
Admits/1000	41	23	3	13	1	81
ALOS	4.56	4.70	6.33	2.46	55.00	4.95
Cost/Day	$2,998	$6,365	$1,024	$1,616	$286	$3,285
Cost/Admit	$13,541	$29,214	$5,700	$3,551	$15,031	$18,227
PMPM	$46.38	$56.61	$1.59	$4.36	$1.20	$110.14
% of Paid	42.11%	51.40%	1.44%	3.96%	1.09%	100.00%

% OF ADMITS FOR ACTUAL



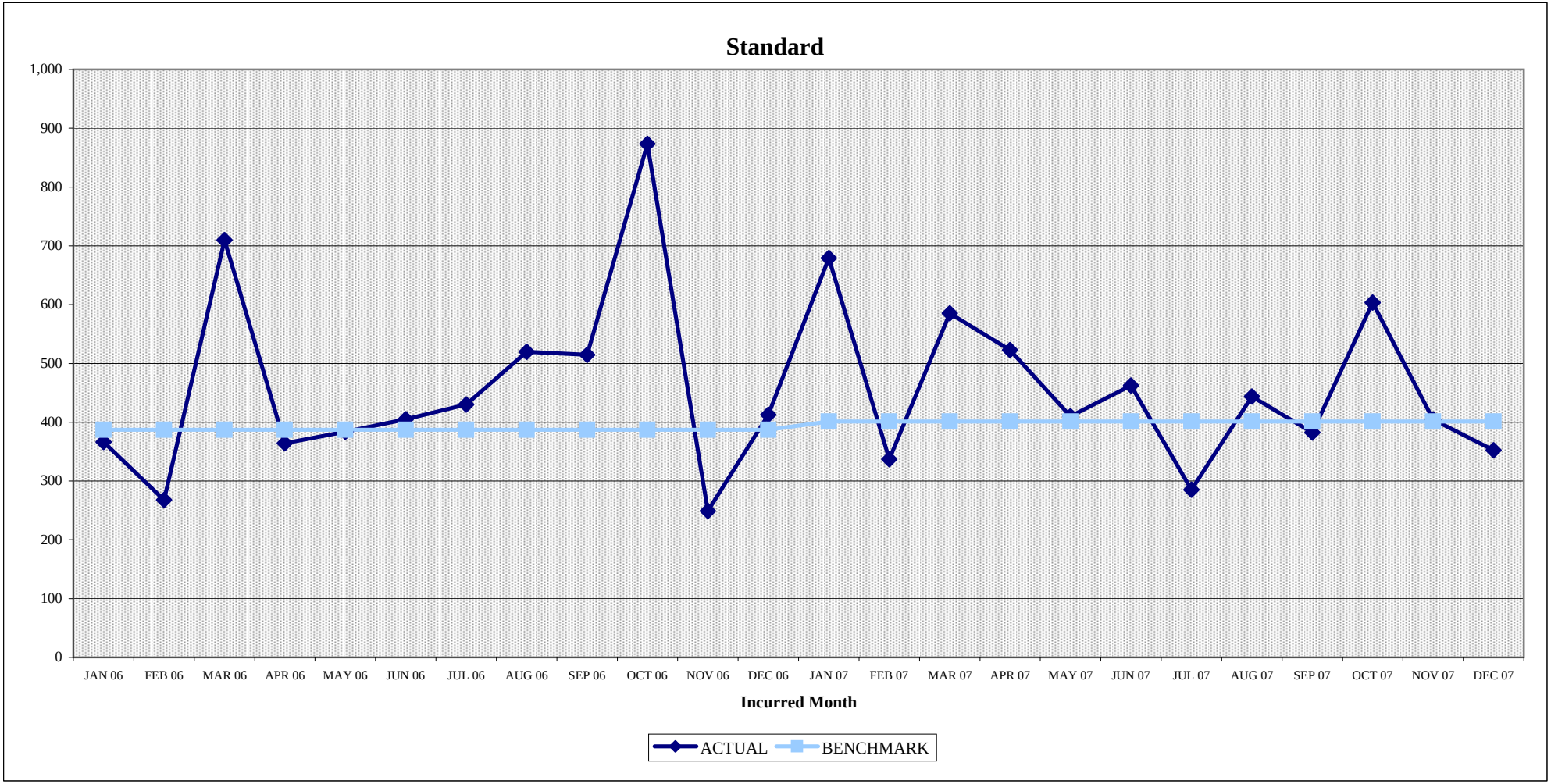
% OF ADMITS FOR BENCHMARK



Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Exhibit 10-B

STATE EMPLOYEE TRUST FUNDS
Monthly Inpatient Days/1000
Paid Through March 2008



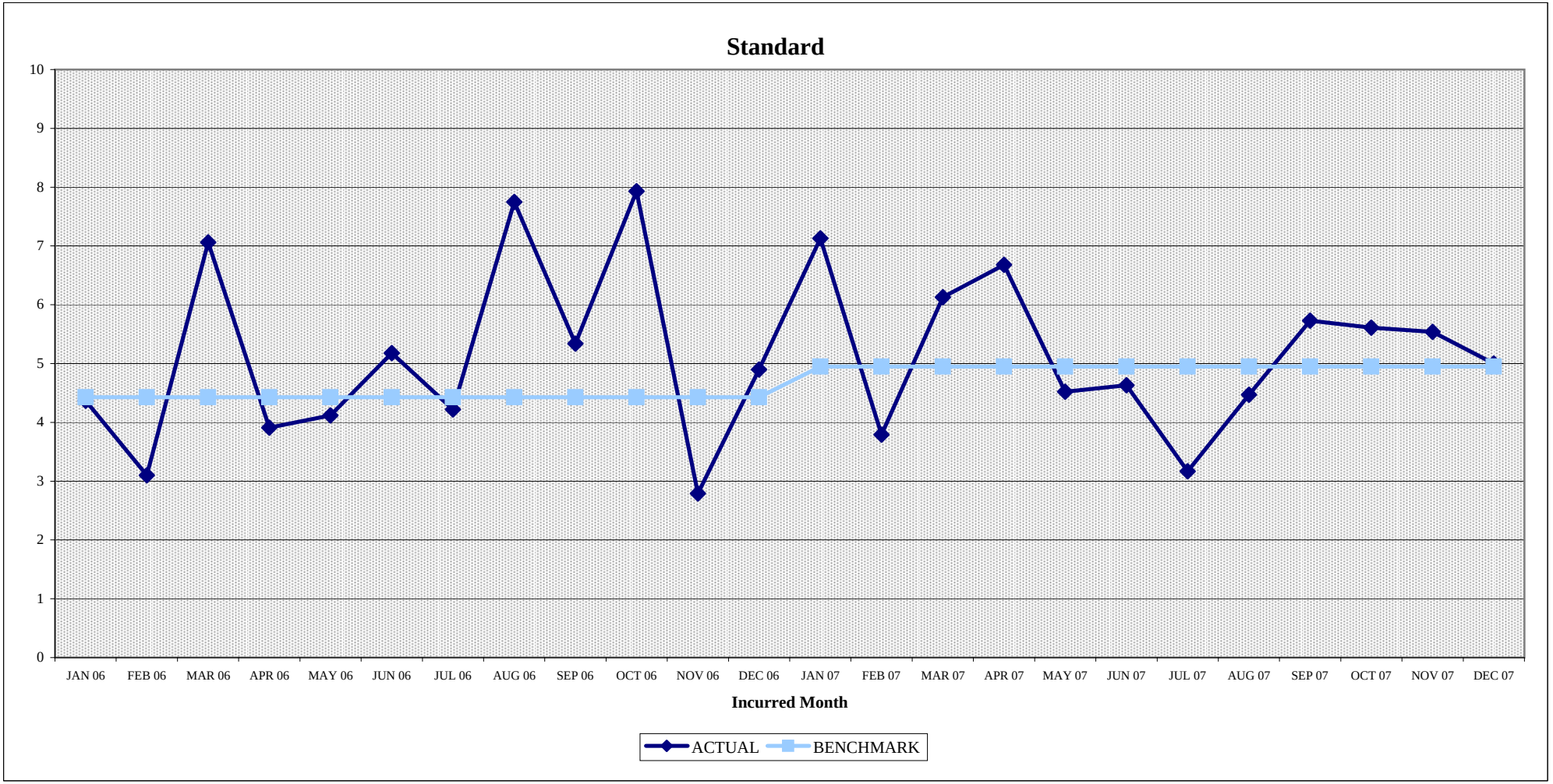
Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Exhibit 10-C

STATE EMPLOYEE TRUST FUNDS

Monthly Inpatient Average Length of Stay

Paid Through March 2008



Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Claim Costs by Major Diagnostic Categories (MDC)

The Claim Costs by Major Diagnostic Categories report divides medical claim costs into 25 mutually exclusive diagnostic categories. The category descriptions have been modified to incorporate simpler, more easily understood terms when compared to last years report. The diagnoses in each MDC correspond to a single organ system and, in general, are associated with a particular medical specialty. The actual PMPM cost by major diagnostic category is compared to the WPS benchmark PMPM. The Actual PMPM costs show calendar year results, comparing 2006 to 2007, each with three months run-out.

Prior exhibits have shown the **Standard Plan's** costs exceed the benchmark overall. Exhibit 11-A shows this deviation by MDC. Variation from the benchmark can be the result of many different factors. Since the benchmark is not adjusted for plan differences we can attribute some variation to non-standard benefits included in the Standard Plan. An example of this is gastric bypass procedures which contributed $16.73 PMPM to MDC 10. Without this non standard benefit, MDC 10 would actually be below the benchmark. We have discovered a membership trend where a high percentage of gastric bypass patients terminated from the plan after the procedure. For example in 2006, the plan had 25 gastric bypass patients. As of the writing of this report, only 5 were still active. For 2007, there were 27 patients, and now only 15 remain active in the plan. This anti-selection tends to increase the cost of the standard plan, and decrease the cost of the other non-WPS benefit offerings. More commentary regarding bariatric surgery, including discussion of the Center of Excellence approach is discussed in section 3.

Another instance of non-standard benefit variance is MDC 19 where the outpatient psychiatric benefit is adding over $13.00 PMPM of additional costs. Additional discussion regarding behavioral health management activities is included in section 3. Another reason for variances from the norm can be the case mix of large claim activity. This is what happened for MDC 17 where the 36 high cost patients accounted for $38.99 PMPM in this category. This change in case mix also leads to the large increase in MDC 17 between 2006 and 2007.

For the Standard Plan $1.00 PMPM in claim costs represented in the chart is equivalent to $46,800 annual in plan costs.

The **SMP Plan,** shown in Exhibit 11-B, is experiencing slightly higher than expected PMPM Cost overall. The large variance seen in MDC 16 and 17 are due to the conditions of the 2 high cost patients. Due to the decreasing size of the group, meaningful conclusions on other individual categories cannot be made. For the SMP Plan $1.00 PMPM in claim cost represented in the charts is equivalent to $6,392 in annual plan costs.

Exhibit 11-A

STATE EMPLOYEE TRUST FUNDS

Claim Costs by Major Diagnostic Categories - Standard

Comparison of 2007 to 2006

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2006 ACTUAL PMPM *	2007 ACTUAL PMPM **	BENCHMARK PMPM **	DIFFERENCE 2007 to 2006	DIFFERENCE 2007 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	$43.60	$42.90	$24.60	-1.6%	74.4%
2	Eye D/D	$12.63	$17.07	$12.25	35.2%	39.4%
3	Ear, Nose, Mouth and Throat D/D	$21.83	$24.30	$16.91	11.3%	43.7%
4	Respiratory System D/D	$22.43	$24.33	$17.94	8.5%	35.7%
5	Circulatory System D/D	$61.36	$66.54	$57.34	8.4%	16.1%
6	Digestive System D/D	$65.00	$53.10	$41.05	-18.3%	29.4%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	$11.03	$13.33	$9.77	20.9%	36.5%
8	Muscles, Bones, and Connective Tissue D/D	$107.33	$106.20	$85.04	-1.1%	24.9%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	$29.91	$40.53	$24.49	35.5%	65.5%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	$29.04	$34.77	$13.71	19.7%	153.7%
11	Kidney and Urinary Tract D/D	$20.72	$19.08	$16.76	-7.9%	13.8%
12	Male Reproductive System D/D	$4.15	$6.34	$4.97	52.8%	27.6%
13	Female Reproductive System D/D	$13.99	$10.78	$13.11	-22.9%	-17.7%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	$5.32	$5.62	$8.09	5.6%	-30.5%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	$1.39	$1.65	$3.86	18.7%	-57.2%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	$8.95	$6.42	$3.82	-28.3%	68.3%
17	Bone Marrow D/D and Poorly Differentiated Cancers	$17.63	$46.67	$11.46	164.7%	307.4%
18	Infectious and Parasitic Diseases	$11.50	$3.05	$4.03	-73.5%	-24.3%
19	Behavioral Health Diagnoses	$37.31	$41.80	$9.28	12.0%	350.5%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	$1.10	$1.31	$1.25	19.1%	5.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	$5.08	$6.55	$4.13	28.9%	58.5%
22	Burns	$0.03	$0.09	$0.21	200.0%	-57.4%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	$55.87	$65.56	$45.14	17.3%	45.2%
24	Multiple Significant Trauma	$0.00	$0.96	$1.19	0.0%	-19.6%
25	Human Immunodeficiency Virus Infections	$0.12	$0.10	$0.05	-16.7%	89.2%
0	Ungroupable	$0.74	$2.57	$1.71	247.3%	50.1%
	Total	**$588.06**	**$641.62**	**$432.13**	**9.1%**	**48.5%**

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Note: The MDC descriptions used in last year's report have been modified in an attempt to help readers understand the type of data that is contained in each category

*** Each $1.00 paid PMPM = $52,016 in plan costs.**

**** Each $1.00 paid PMPM = $46,800 in plan costs.**

Exhibit 11-B

STATE EMPLOYEE TRUST FUNDS
Claim Costs by Major Diagnostic Categories - SMP
Comparison of 2007 to 2006

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2006 ACTUAL PMPM *	2007 ACTUAL PMPM **	BENCHMARK PMPM **	DIFFERENCE 2007 to 2006	DIFFERENCE 2007 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	$13.59	$10.52	$19.17	-22.6%	-45.1%
2	Eye D/D	$12.47	$5.09	$8.18	-59.2%	-37.8%
3	Ear, Nose, Mouth and Throat D/D	$18.63	$12.51	$16.52	-32.9%	-24.3%
4	Respiratory System D/D	$8.90	$11.05	$13.21	24.2%	-16.4%
5	Circulatory System D/D	$32.76	$34.17	$41.51	4.3%	-17.7%
6	Digestive System D/D	$34.19	$40.61	$33.57	18.8%	21.0%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	$6.37	$10.76	$7.98	68.9%	34.8%
8	Muscles, Bones, and Connective Tissue D/D	$71.66	$78.70	$63.27	9.8%	24.4%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	$22.38	$12.76	$18.13	-43.0%	-29.6%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	$11.31	$5.91	$10.53	-47.7%	-43.9%
11	Kidney and Urinary Tract D/D	$11.02	$7.74	$12.11	-29.8%	-36.1%
12	Male Reproductive System D/D	$4.28	$5.94	$3.79	38.8%	56.6%
13	Female Reproductive System D/D	$18.70	$6.63	$11.23	-64.5%	-40.9%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	$10.84	$15.53	$9.33	43.3%	66.5%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	$7.35	$7.23	$5.28	-1.6%	36.8%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	$2.95	$13.68	$2.96	363.7%	362.0%
17	Bone Marrow D/D and Poorly Differentiated Cancers	$8.62	$35.18	$8.48	308.1%	315.0%
18	Infectious and Parasitic Diseases	$2.45	$1.37	$3.51	-44.1%	-61.0%
19	Behavioral Health Diagnoses	$9.14	$6.48	$9.13	-29.1%	-29.0%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	$0.87	$0.91	$1.36	4.6%	-33.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	$2.25	$2.59	$3.49	15.1%	-25.8%
22	Burns	$0.36	$0.06	$0.28	-83.3%	-78.9%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	$37.08	$32.61	$35.59	-12.1%	-8.4%
24	Multiple Significant Trauma	$0.00	$0.00	$1.14	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	$0.21	$0.00	$0.05	-100.0%	-100.0%
0	Ungroupable	$0.58	$0.46	$1.47	-20.7%	-68.7%
	Total	**$348.96**	**$358.49**	**$341.25**	**2.7%**	**5.1%**

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Note: The MDC descriptions used in last year's report have been modified in an attempt to help readers understand the type of data that is contained in each category

*** Each $1.00 paid PMPM = $97,961 in plan costs.**

**** Each $1.00 paid PMPM = $6,392 in plan costs.**

Top 20 Providers

The Top 20 Provider reports display the top 20 Facility and Professional Providers sorted by total paid charges. Within the facility report, charges have also been broken out by Inpatient and Outpatient paid charges for additional analysis. The Paid % shows the percentage of the group's total facility or professional charges from a specific provider.

Facility

The report for the **Standard Plan** in Exhibit 12-A shows that the top 20 facilities provide 57.1% of the total facility charges for the plan. By far, the largest percent of claims and number of patients came from the University of Wisconsin hospital. Second was Columbia St. Marys in Milwaukee. As expected, a concentration of the top 20 facility providers are located in the Dane and Milwaukee County areas where a majority of the Standard Plan population resides. Since the Standard Plan is available nationwide, however, we do see providers from various regions and states.

The report for the **SMP Plan** in Exhibit 12-B shows that the top 20 facilities provide 97.3% of the total facility charges for the plan. The largest percentage of paid claims is from Bay Area Medical Center in Marinette. The provider with the second highest amount of paid claims is the University of Wisconsin Hospital, though this was for only one claimant.

Professional

The **Standard Plan** shown in Exhibit 12-C received 44.4% of professional charges from the top 20 providers. Once again the University of Wisconsin Medical Foundation is the leading professional provider which corresponds to the top facility charges for the plan. Like the facility charges a concentration of the top providers are from the Dane and Milwaukee Counties regions.

The **SMP Plan** in Exhibit 12-D received 74.1% of the paid claims from the top 20 professional providers. Bay Area / Bellin Health in Marinette was the largest provider, receiving 10.4% of the overall payments, followed by Aurora Medical in Oshkosh at 9.7%. Like the facility charges we see a majority of the charges are received at regional facilities due to the HMO-type coverage and the limited service area. You can also see some services were received in Minnesota and Michigan since the SMP does have limited coverage in the states surrounding Wisconsin.

Exhibit 12-A

STATE EMPLOYEE TRUST FUNDS

Top 20 Facility Providers - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	619	$782,146	$1,861,801	$2,643,947	15.5%
2	CSM COMMUNITY PHYSICIANS	MILWAUKEE	WI	221	$376,819	$507,608	$884,427	5.2%
3	FROEDTERT MEM LUTH HOSP	MILWAUKEE	WI	119	$442,994	$369,745	$812,739	4.8%
4	MERITER HOSPITAL INC	MADISON	WI	144	$384,204	$378,418	$762,622	4.5%
5	SOUTHWESTERN REGIONAL MEDICAL	TULSA	OK	1	$84,583	$364,176	$448,759	2.6%
6	ALL SAINTS ST MARYS MED CTR	RACINE	WI	85	$149,133	$272,683	$421,816	2.5%
7	WAUKESHA MEM HSP INC	WAUKESHA	WI	39	$306,549	$106,356	$412,905	2.4%
8	AURORA ST LUKES MEDICAL CTR	MILWAUKEE	WI	80	$178,015	$227,003	$405,018	2.4%
9	CLEVELAND CLINIC FOUNDATION	CLEVELAND	OH	3	$155,041	$226,246	$381,287	2.2%
10	AURORA SINAI SAMARTN MED CTR	MILWAUKEE	WI	32	$6,366	$341,950	$348,316	2.0%
11	FAIRVIEW UNIVERSITY MED CTR	MINNEAPOLIS	MN	14	$277,305	$53,837	$331,142	1.9%
12	LENOX HILL HOSP	NEW YORK	NY	1	$304,099	$0	$304,099	1.8%
13	SACRED HEART HOSP	EAU CLAIRE	WI	19	$232,964	$50,549	$283,513	1.7%
14	ST MARYS HOSP OZAUKEE	MEQUON	WI	49	$49,793	$156,910	$206,703	1.2%
15	ST MARYS HSP-ROCHESTER	ROCHESTER	MN	13	$129,797	$65,825	$195,622	1.1%
16	THOMAS JEFFERSON HOSPITAL	PHILADELPHIA	PA	2	$183,904	$4,471	$188,375	1.1%
17	ABBOTT NORTHWESTERN HOSPITAL	MINNEAPOLIS	MN	19	$157,902	$30,382	$188,284	1.1%
18	SAINT MICHAELS HOSP	STEVENS POINT	WI	18	$126,525	$61,319	$187,844	1.1%
19	LUTHER HOSPITAL	EAU CLAIRE	WI	32	$97,379	$86,885	$184,264	1.1%
20	TRIDENT MEDICAL CTR	CHARLESTON	SC	2	$119,999	$59,933	$179,932	1.1%
	Top 20 Total			**1,512**	**$4,545,517**	**$5,226,097**	**$9,771,614**	**57.1%**
	All Other Facility Charges			**1,663**	**$3,339,902**	**$3,997,221**	**$7,337,123**	**42.9%**
	Total Facility Charges			**3,175**	**$7,885,419**	**$9,223,318**	**$17,108,737**	**100.0%**

Exhibit 12-B

STATE EMPLOYEE TRUST FUNDS

Top 20 Facility Providers - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	BAY AREA MEDICAL CTR	MARINETTE	WI	95	$142,667	$235,293	$377,960	32.3%
2	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	1	$65,142	$61,501	$126,643	10.8%
3	MEMORIAL MED CTR INC	ASHLAND	WI	31	$27,330	$94,529	$121,859	10.4%
4	ABBOTT NORTHWESTERN HOSPITAL	MINNEAPOLIS	MN	29	$21,166	$54,605	$75,771	6.5%
5	AURORA BAYCARE MED CTR	GREEN BAY	WI	6	$35,046	$38,908	$73,954	6.3%
6	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	32	$16,340	$53,020	$69,360	5.9%
7	ST MARYS MED CTR	DULUTH	MN	4	$31,795	$15,154	$46,949	4.0%
8	BURNETT MEDICAL CENTER INC	GRANTSBURG	WI	14	$0	$46,697	$46,697	4.0%
9	ST MARYS HSP-ROCHESTER	ROCHESTER	MN	1	$38,540	$0	$38,540	3.3%
10	BELLIN MEMORIAL HOSP	GREEN BAY	WI	5	$26,619	$7,780	$34,399	2.9%
11	ST JOSEPHS HOSPITAL	MARSHFIELD	WI	1	$33,436	$0	$33,436	2.9%
12	ST VINCENT HOSPITAL	GREEN BAY	WI	2	$22,986	$4,239	$27,225	2.3%
13	GRAND VIEW HOSP	IRONWOOD	MI	9	$0	$18,156	$18,156	1.6%
14	MARQUETTE GENERAL HOSPITAL INC	MARQUETTE	MI	3	$11,733	$2,119	$13,852	1.2%
15	IRON CO COMM HOSPITAL	IRON RIVER	MI	2	$2,709	$4,782	$7,491	0.6%
16	ROCHESTER METHODIST HOSPITAL	ROCHESTER	MN	1	$0	$7,114	$7,114	0.6%
17	ST MARYS HOSPITAL OF SUPERIOR	SUPERIOR	WI	1	$0	$5,771	$5,771	0.5%
18	ONTONAGON MEM HOSP	ONTONAGON	MI	2	$2,797	$2,356	$5,153	0.4%
19	SAINT MICHAELS HOSP	STEVENS POINT	WI	2	$1,202	$2,904	$4,106	0.4%
20	DIVINE SAVIOR HOSP	PORTAGE	WI	1	$0	$4,097	$4,097	0.4%
	Top 20 Total			**242**	**$479,508**	**$659,025**	**$1,138,533**	**97.3%**
	All Other Facility Charges			**37**	**$300**	**$31,032**	**$31,332**	**2.7%**
	Total Facility Charges			**279**	**$479,808**	**$690,057**	**$1,169,865**	**100.0%**

Exhibit 12-C

STATE EMPLOYEE TRUST FUNDS

Top 20 Professional Providers - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	UW MEDICAL FOUNDATION	MADISON	WI	806	$1,714,097	13.3%
2	MAYO CLINIC ROCHESTER	ROCHESTER	MN	77	$563,198	4.4%
3	MEDICAL COLLEGE OF WISCONSIN	MILWAUKEE	WI	215	$522,205	4.0%
4	DEAN MEDICAL CTR	MADISON	WI	272	$456,835	3.5%
5	MARSHFIELD CLINIC	MARSHFIELD	WI	90	$451,991	3.5%
6	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	275	$399,545	3.1%
7	ADVANCED HEALTHCARE SC	MILWAUKEE	WI	179	$252,793	2.0%
8	MIDELFORT CLINIC MHS	EAU CLAIRE	WI	104	$218,480	1.7%
9	ONCOLOGY ALLIANCE SC	RACINE	WI	11	$210,635	1.6%
10	WHEATON FRANCISCAN MEDICAL GRP	RACINE	WI	120	$151,720	1.2%
11	CSM COMMUNITY PHYSICIANS	MILWAUKEE	WI	194	$145,857	1.1%
12	ASSOCIATED PHYSICIANS LLP	MADISON	WI	139	$111,378	0.9%
13	SAINT MICHAELS HOSP	STEVENS POINT	WI	37	$87,966	0.7%
14	GUNDERSEN CLINIC LTD	LA CROSSE	WI	34	$87,651	0.7%
15	BAYCARE CLINIC LLP	GREEN BAY	WI	26	$74,479	0.6%
16	MADISON PSYCH & PSYCH SVC	MADISON	WI	23	$67,428	0.5%
17	MADISON MEDICAL AFFILIATES INC	MEQUON	WI	78	$57,340	0.4%
18	RED CEDAR MEDICAL CTR	MENOMONIE	WI	49	$55,520	0.4%
19	AFFINITY MEDICAL GROUP	NEENAH	WI	51	$53,559	0.4%
20	MILWAUKEE RADIOLOGISTS LTD SC	MILWAUKEE	WI	94	$50,216	0.4%
	Top 20 Total			**2,874**	**$5,732,893**	**44.4%**
	All Other Professional Charges			**10,095**	**$7,185,431**	**55.6%**
	Total Professional Charges			**12,969**	**$12,918,324**	**100.0%**

Exhibit 12-D

STATE EMPLOYEE TRUST FUNDS

Top 20 Professional Providers - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	BAY AREA BELLIN HEALTH LLC	MARINETTE	WI	144	$116,092	10.4%
2	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	48	$108,875	9.7%
3	DULUTH CLINIC LTD	DULUTH	MN	49	$108,132	9.6%
4	BAY AREA MEDICAL CTR	MARINETTE	WI	34	$83,668	7.5%
5	BAYCARE CLINIC LLP	GREEN BAY	WI	10	$65,543	5.8%
6	RIVER FALLS MEDICAL CLINIC	RIVER FALLS	WI	73	$50,389	4.5%
7	MINNESOTA ONCOLOGY HEMATOLOGY	MAPLEWOOD	MN	2	$46,861	4.2%
8	MARSHFIELD CLINIC	MARSHFIELD	WI	11	$38,253	3.4%
9	MAYO CLINIC ROCHESTER	ROCHESTER	MN	1	$35,591	3.2%
10	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	1	$24,244	2.2%
11	GREEN BAY RADIOLOGY SC	GREEN BAY	WI	68	$21,374	1.9%
12	NARAYAN AMARNANI MD SC OUTREAC	MARINETTE	WI	14	$19,694	1.8%
13	BURNETT MEDICAL CENTER INC	GRANTSBURG	WI	15	$18,608	1.7%
14	UW MEDICAL FOUNDATION	MADISON	WI	2	$17,818	1.6%
15	NORTHERN LIGHTS CLINIC SC	MARINETTE	WI	19	$15,658	1.4%
16	IHC BAY AREA EMERGENCY PHYSICI	MARINETTE	WI	33	$14,153	1.3%
17	HENKE & RYAN PC	IRON MOUNTAIN	MI	5	$12,261	1.1%
18	MAINSTREET CLINIC SC	ASHLAND	WI	25	$11,799	1.1%
19	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	34	$11,720	1.0%
20	NEONATAL CONSULTANTS	GREEN BAY	WI	1	$10,791	1.0%
	Top 20 Total			**589**	**$831,524**	**74.1%**
	All Other Professional Charges			**569**	**$290,086**	**25.9%**
	Total Professional Charges			**1,158**	**$1,121,610**	**100.0%**

Out of Network Utilization

The Out of Network Utilization reports in exhibit 13-A and 13-B display the top 20 out of network facility providers and top 20 out of network professional providers for the Standard Plan sorted by total paid charges. Within the facility report, charges have been broken out by Inpatient and Outpatient paid charges for additional analysis.

Facility

The **Standard Plan** out of network facility utilization was 6.5% of the total facility claims for the plan in 2007, slightly higher than last year's facility utilization number of 3.9%. The 2006 number was calculated using a slightly different methodology. 12 of the 20 out of network providers were from outside the state which is expected given 24.1% of the Standard Plan population lives outside the state of Wisconsin and are more likely to see an out of network provider depending on location.

Professional

The **Standard Plan** out of network professional utilization was 10.2% of the total professional claims for the plan in 2007. While last year's report showed better network utilization, (out of network claims were equal to 6.3% in 2006), last year's number was calculated via a different methodology. 19 of the top 20 professional providers practice in Wisconsin.

Exhibit 13-A

STATE EMPLOYEE TRUST FUNDS

Facility Out of Network Utilization - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims
1	TRIDENT MEDICAL CTR	CHARLESTON	SC	2	$119,998.75	$59,933.14	$179,931.89
2	SOUTHWESTERN REGIONAL MEDICAL	TULSA	OK	2	$0.00	$167,014.27	$167,014.27
3	SELECT SPECIALTY HOSPITAL	WEST ALLIS	WI	1	$148,782.33	$0.00	$148,782.33
4	LAKEVIEW REHABILITATION CTR	WATERFORD	WI	1	$145,490.37	$0.00	$145,490.37
5	SUMMIT SURGERY CTR	SANTA BARBARA	CA	1	$0.00	$44,171.00	$44,171.00
6	COPLEY MEM HOSP	AURORA	IL	1	$0.00	$28,787.12	$28,787.12
7	HENRY FORD HOME CARE	DETROIT	MI	1	$0.00	$27,322.32	$27,322.32
8	WISCONSIN RENAL CARE GRP	MILWAUKEE	WI	3	$0.00	$25,521.26	$25,521.26
9	MT CARMEL NEW ALBANY SURG	NEW ALBANY	OH	1	$24,995.76	$0.00	$24,995.76
10	YALE NEW HAVEN HOSPITAL	NEW HAVEN	CT	1	$21,358.57	$0.00	$21,358.57
11	HOPE HOSPICE	FORT MYERS	FL	1	$15,398.80	$0.00	$15,398.80
12	TRINITY HEALTHCARE	MILWAUKEE	WI	2	$15,271.39	$0.00	$15,271.39
13	CEDAR SPRINGS HEALH AND REHABI	CEDARBURG	WI	2	$13,736.98	$0.00	$13,736.98
14	MANORCARE HEALTH SVC	FOND DU LAC	WI	1	$11,927.50	$0.00	$11,927.50
15	MILW CO M/H COMPLEX	MILWAUKEE	WI	2	$10,322.00	$0.00	$10,322.00
16	MERCY MEMORIAL HEALTH CTR	OKLAHOMA CITY	OK	1	$8,283.33	$1,890.17	$10,173.50
17	MEMORIAL HOSP	COLORADO SPRINGS	CO	1	$0.00	$9,924.75	$9,924.75
18	900 NORTH MICHIGAN SURG CTR	CHICAGO	IL	1	$0.00	$9,718.40	$9,718.40
19	EVERGREEN RETIREMENT	OSHKOSH	WI	1	$9,281.80	$0.00	$9,281.80
20	SANTA BARBARA SURGERY CENTER	SANTA BARBARA	CA	1	$0.00	$9,231.30	$9,231.30
TOTAL				**27**	**$544,847.58**	**$383,513.73**	**$928,361.31**

Exhibit 13-B

STATE EMPLOYEE TRUST FUNDS

Professional Out of Network Utilization - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims
1	MADISON PSYCH & PSYCH SVC	MADISON	WI	23	$67,428.00
2	WISCONSIN RENAL CARE GRP	MILWAUKEE	WI	3	$46,617.52
3	WISCONSIN PSYCHOTHERAPY & HE	MADISON	WI	6	$40,587.75
4	WOMENS PSYCHIATRIC CENTER OF W	MADISON	WI	7	$39,820.50
5	RICHARD A FRANK MD SC	MILWAUKEE	WI	9	$35,690.22
6	NEWPORT PROFESSIONALS LTD	MEQUON	WI	5	$25,308.00
7	MEDICAL SUPPRT SRV INC	RACINE	WI	1	$20,541.27
8	ROBERT L WELKER PHD	GLENDALE	WI	4	$15,286.50
9	DOPSYCH SC	GREEN BAY	WI	2	$14,845.04
10	BELL AMBULANCE	MILWAUKEE	WI	9	$14,094.96
11	BETH ISRAEL HAND SURGERY CENTE	NEW YORK	NY	1	$13,695.00
12	COUNSELING ASSOCIATES MADISON	MADISON	WI	8	$13,322.37
13	RIVERHILL PSYCHIATRIC ASSOCIAT	MANITOWOC	WI	4	$13,281.32
14	MARCI M GITTLEMAN PHD	MADISON	WI	8	$12,307.50
15	GOODYEAR CHIROPRACTIC	GLENDALE	WI	4	$11,318.36
16	SILVER SPRING PSYCHIATRIC ASSO	MILWAUKEE	WI	5	$11,308.50
17	IKAR J KALOGJERA MD	WAUWATOSA	WI	6	$10,731.27
18	JAN C VAN SCHAIK MD	WHITEFISH BAY	WI	1	$10,692.00
19	EASTLAKE COUNSELING	MILWAUKEE	WI	5	$10,518.75
20	WISCONSIN EARLY AUTISM PROJECT	MADISON	WI	4	$10,201.63
	TOTAL			**115**	**$437,596.46**

High Cost Patients

The High Cost Patients report in Exhibit 14-A lists the plan members with claims over $100,000 for claims incurred January 2007 – December 2007 and paid through March 2008 for the Standard, SMP and Medicare Plus $1M Plans. The Primary Condition is the condition associated with the largest percentage of claim payments and therefore may not be representative of a patient's complete condition. The Care Management section shows the type of care management provided on each case. For a detailed description of care management processes please reference the Case Management Description on the next page.

In general, cancer diagnoses accounted for 40% of the high dollar cases and 49% of the total high dollar claims. Of the cancer claims, breast cancer was the most prevalent with six breast cancer patients out of the 17 total cancer patients. Two members in the high cost category had behavioral health diagnoses. All members with high dollar claims received intensive care management service.

The **Standard Plan** has 36 members with claims over $100,000 for a total of $7,719,465 in claim costs. Of these 36 members 20 are employees, 13 are spouses, and 3 are dependents. Another way to break down these members is that 22 are regular members, 13 are annuitants, and 1 is a graduate assistant. 26 of the members reside in state and 10 are out of state. These 36 members represent 22.0% of total claims paid under the Standard Plan. The expected percent of claims over $100,000 for a group of this size is 6.0%, whereas for the Standard Plan, they have 11.7% of claims over $100,000. Therefore, large claim activity is much higher than expected.

The **SMP Plan** has 2 members with claims over $100,000 for a total of $345,831 in claim costs. One of the members is an employee and the other is a spouse, while both are regular members. Both large claimants for the SMP Plan reside in Wisconsin. These 2 members represent 13.6% of total claims paid under the SMP Plan. .

The **Medicare Plus $1M Plan** has 4 members with claims over $100,000 for a total $466,192 in claim costs. Three members reside in Wisconsin and one resides out of state. One member is a foreign resident and claims were incurred at a foreign provider. There are limited opportunities for repricing of claims performed at foreign providers. For two of the other claimants, Medicare benefits were exhausted, and the state plan paid for the excess charges. The forth claimant labeled in this category recently changed from the Standard Plan to the Medicare Plus $1M Plan, so some of the claims were actually incurred while on the Standard Plan.

Case Management Descriptions

The following is a brief description of the case management categories used in the High Cost Patient report.

Utilization Management helps ensure members achieve proper utilization of services, while maximizing their health care benefits, as well as determining the most appropriate level of care. Case Management Care nurses monitor patient care through preadmission or precertification review, inpatient admission and concurrent review, discharge planning with referrals to Case or Disease Management nurses, and outpatient services review.

Preauthorization is review of specific outpatient services, including surgical services, diagnostic services, and referrals, and determination that these services meet the criteria for medical necessity under the member's benefit plan.

Medical Review is an additional process in the Medical Affairs area that does post-claim review to ensure that those services that received prior approval are billed appropriately, and/or that services billed are covered by the member's plan, and are medically necessary.

Case Management is assessing, planning and facilitating services for members involved in an acute or catastrophic medical situation. The Case Manager focuses on managing the utilization of benefits within the confines of the policy, in the most effective manner; ensuring quality of care is not compromised. Examples of Acute Case Management are inpatient rehabilitation cases, long term inpatient cases, or short term home care cases that require skilled nursing visits and/or intravenous (IV) therapy. All of these cases are closely managed by the case managers.

Chronic Condition (Disease) Management utilizes a proactive approach through education, treatment and appropriate care to prevent long-term and unnecessary complications of chronic disease. Through education, the Chronic Condition Manager empowers members to take ownership of their health, decreasing future health risks, minimizing the need for medical services, and ultimately, improving the quality of life.

Exhibit 14-A

STATE EMPLOYEE TRUST FUNDS

High Cost Patients (over $100,000)

Incurred January 2007 - December 2007 Paid Through March 2008

	Patient Status	Plan	Care Management	Primary Condition	Total Paid
1	ACTIVE	STANDARD	Preauth, UM, CM	MYELOID LEUKEMIA	$569,049.29
2	CANCELLED	STANDARD	UM, CM	OVARIAN/COLON CANCER	$486,855.85
3	ACTIVE	STANDARD	Preauth, UM, CM	AORTIC ANEURYSM	$470,925.01
4	ACTIVE	STANDARD	UM, CM	HODGKINS DISEASE	$438,069.45
5	ACTIVE	STANDARD	UM, CM	STROKE	$415,843.18
6	CANCELLED	STANDARD	Preauth, UM, CM	BRAIN CANCER	$387,537.12
7	ACTIVE	STANDARD	UM, BH	BEHAVIORAL HEALTH	$348,459.76
8	CANCELLED	STANDARD	UM, CM	BREAST/LIVER CANCER	$286,609.48
9	CANCELLED	STANDARD	Preauth, UM, CM	EYE/LIVER CANCER	$258,618.75
10	CANCELLED	STANDARD	UM, CM	BREAST CANCER	$254,227.96
11	CANCELLED	STANDARD	Preauth, UM, CM	CHRONIC PANCREATITIS	$251,863.51
12	ACTIVE	STANDARD	Preauth, UM, CM	BREAST CANCER	$250,050.67
13	CANCELLED	SMP	Preauth, UM, CM	NON HODGKINS DISEASE	$242,995.81
14	ACTIVE	STANDARD	Preauth, UM	SPINAL STENOSIS/LUMBAR FUSION	$179,996.53
15	CANCELLED	STANDARD	Preauth,UM	SPINAL STENOSIS/LUMBAR FUSION	$177,940.70
16	CANCELLED	STANDARD	UM, CM	AORTIC ANEURYSM	$174,739.85
17	ACTIVE	STANDARD	UM, CM	CHRONIC RENAL FAILURE	$174,508.17
18	ACTIVE	STANDARD	UM, CM	HEART VALVE DEFECT	$170,858.00
19	CANCELLED	STANDARD	UM, CM	CHRONIC LEUKEMIA	$161,404.08
20	ACTIVE	STANDARD	UM, CM	PLASMA CELL CANCER	$158,642.11
21	CANCELLED	STANDARD	UM, CM	BACTERIAL PNEUMONIA	$153,896.72
22	ACTIVE	STANDARD	UM, DM	SPINAL STENOSIS/LUMBAR FUSION	$152,554.88
23	CANCELLED	STANDARD	UM	HEART VALVE DISORDER	$152,381.65
24	ACTIVE	STANDARD	UM, BH	KNEE REPLACEMENT	$146,258.11
25	ACTIVE	STANDARD	Preauth, UM, CM	CYSTIC FIBROSIS COMPLICATIONS	$143,558.18
26	ACTIVE	STANDARD	Preauth, UM, CM	TONSIL CANCER	$140,693.13
27	ACTIVE	MEDICARE PLUS ONE MILLION	DM	HEART FAILURE	$131,886.85
28	ACTIVE	STANDARD	Preauth, UM, CM	TRACHEA/LUNG CANCER	$126,402.18
29	ACTIVE	STANDARD	UM	CURVATURE OF SPINE/LUMBAR FUSION	$122,365.84
30	ACTIVE	MEDICARE PLUS ONE MILLION	Medical Review	CHRONIC PULMONARY HEART DISEASE	$121,315.02
31	ACTIVE	STANDARD	Preauth, UM, BH	BEHAVIORAL HEALTH	$121,174.63
32	ACTIVE	STANDARD	Preauth,UM, BH, CM	BREAST CANCER	$109,617.45

Preauth = Preauthorization UM = Utilization Management CM = Case Management DM = Disease Management BH = Behavioral Health

Exhibit 14-A

STATE EMPLOYEE TRUST FUNDS

High Cost Patients (over $100,000)

Incurred January 2007 - December 2007 Paid Through March 2008

	Patient Status	Plan	Care Management	Primary Condition	Total Paid
33	ACTIVE	STANDARD	Preauth, UM, CM	INFLAM/TOXIC NEUROPATHY	$109,211.53
34	ACTIVE	STANDARD	Preauth, UM, CM	RECTUM/ANUS CANCER	$108,666.45
35	CANCELLED	MEDICARE PLUS ONE MILLION	UM, CM	STROKE	$108,220.39
36	ACTIVE	STANDARD	UM, CM	ESSENTIAL HYPERTENSION	$107,703.02
37	ACTIVE	STANDARD	CM	BREAST CANCER	$105,860.71
38	ACTIVE	MEDICARE PLUS ONE MILLION	UM	ENCEPHALOPATHY, RESPIRATORY FAILURE	$104,770.08
39	CANCELLED	SMP	UM, CM	KNEE REPLACEMENT	$102,834.80
40	ACTIVE	STANDARD	Preauth, UM, CM	INFANTILE CEREBRAL PALSY	$102,177.97
41	ACTIVE	STANDARD	Preauth, UM	BREAST CANCER	$100,466.34
42	ACTIVE	STANDARD	UM	SEVERE INTESTINAL INFLAMMATION	$100,276.87
Total					**$8,531,488.08**

Preauth = Preauthorization UM = Utilization Management CM = Case Management DM = Disease Management BH = Behavioral Health

Note: Total paid includes medical and drug data

Note: Descriptions of the Care Management functions may be found in Section 3 pages 1a and 1b

Medical and Drug Cost Sharing

The Medical and Drug Cost Sharing graphs in Exhibit 15-A show the percent of eligible medical and drug claim costs paid by the member. This percentage is compared to the WPS benchmark.

The **Standard Plan** members pay about 2.6% of their own medical claims as compared to the benchmark of 7.4%. The prescription drug cost share is slightly closer to our normative benchmark with the Standard Plan around 16.0% and the benchmark at 19.6%.

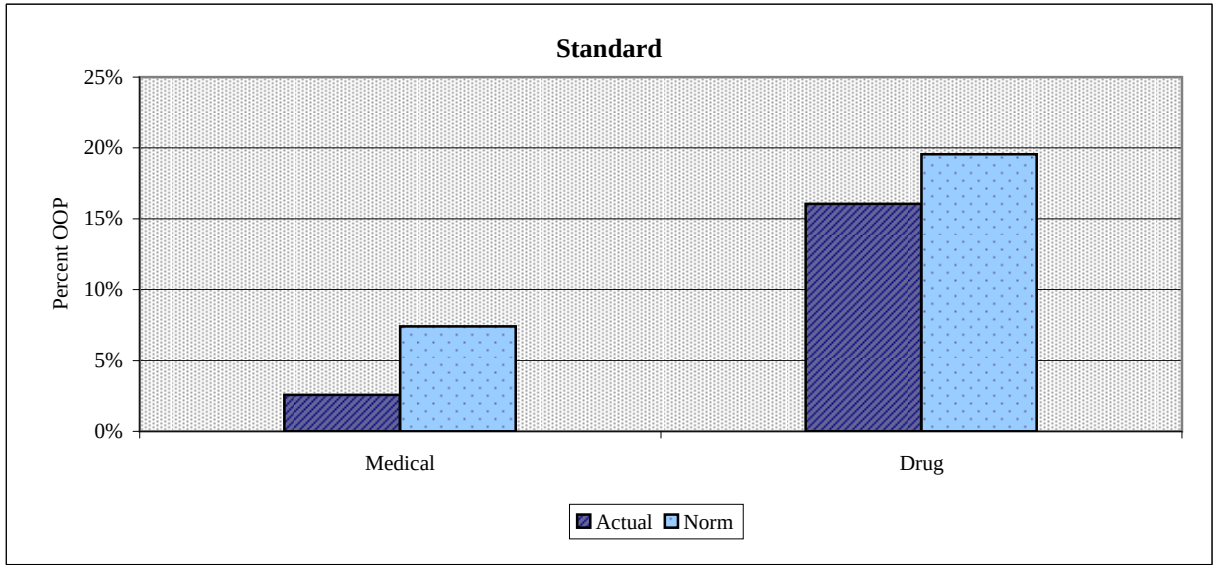
The **SMP Plan** members by comparison pay almost nothing towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 8.3% of their medical claims. The SMP cost share for prescription drugs is just over 17% compared to the benchmark of 19.5%. Even though the Standard and SMP Plans have the same prescription drug benefit, they have slightly different drug utilization profiles, which is the result of each plan's unique blend of treated conditions.

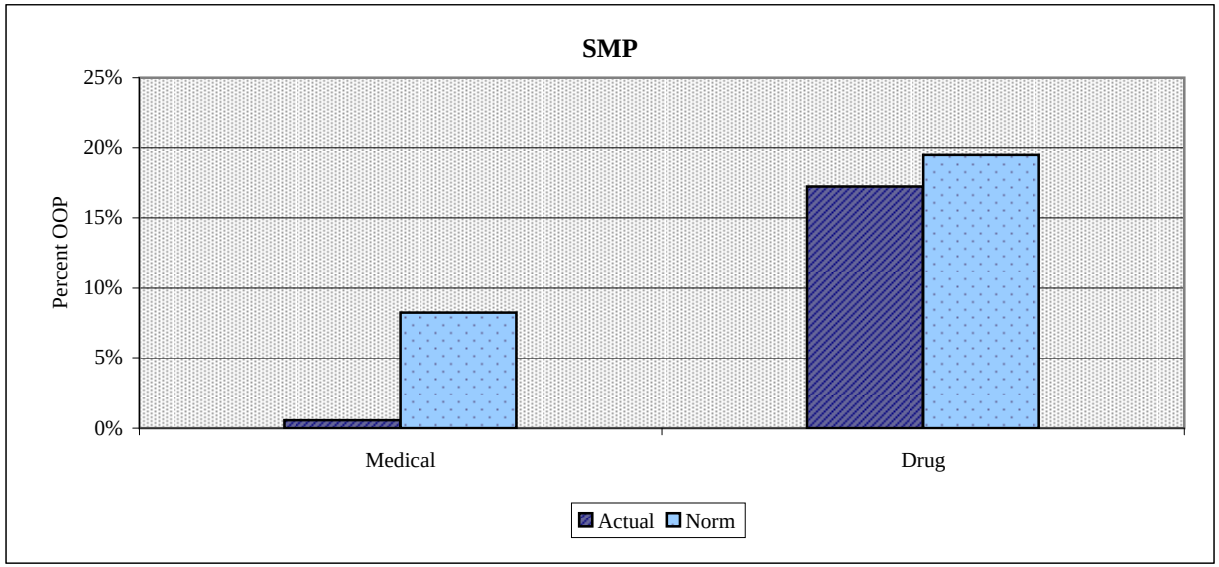
Exhibit 15-A

STATE EMPLOYEE TRUST FUNDS

Medical and Drug Cost Sharing

Incurred January 2007 - December 2007 Paid Through March 2008





Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Medical and Drug Out of Pocket by Member

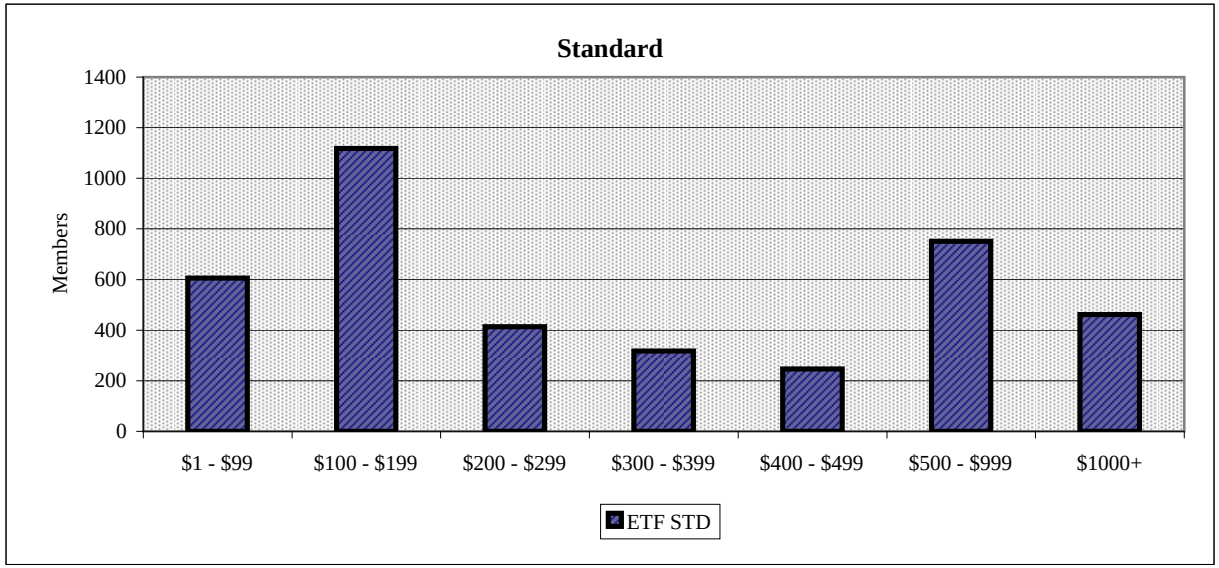
The Medical and Drug Out of Pocket by Member bar graph shown in Exhibit 16-A divides members with out of pocket cost sharing into categories based on the annual amount of out of pocket costs they paid in 2007. The annual out of pocket for each member includes medical and prescription drug costs.

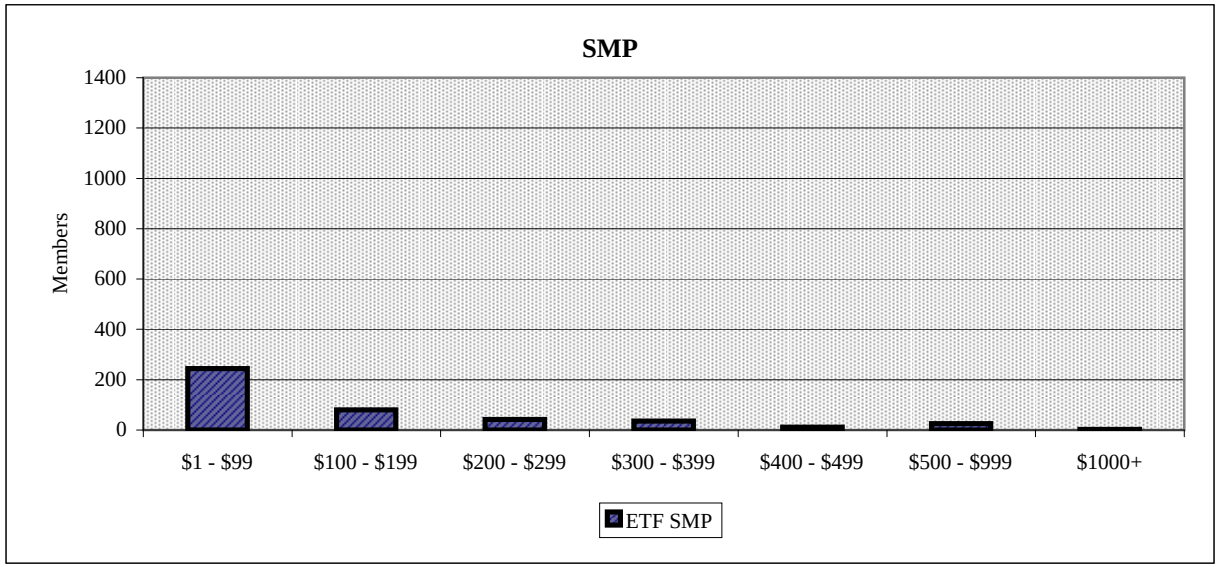
The **Standard Plan** has a large disparity between the members as far as out of pocket costs. A good portion of members pay between $100 and $200 out of pocket annually. There are also almost 800 members in the $500 to $999 range but it is important to note the range for this category is larger than the previous categories. Lastly, there are over 400 members who pay over $1000 out of pocket annually.

The **SMP Plan** by comparison has a large number of all members paying between $1and $99 in cost sharing. Most of the cost sharing comes from prescription drug copays.

Exhibit 16-A

STATE EMPLOYEE TRUST FUNDS
Medical and Drug Out of Pocket by Member
Incurred January 2007 - December 2007 Paid Through March 2008





Medical Claim Savings Analysis

The Medical Claim Saving Analysis in Exhibit 17-A takes the charges submitted on behalf of the ETF members and details the savings that take place before the final payments are made to the providers. The submitted charges represent medical claims only. The charges are split between the Standard, SMP and Medicare Plus $1M Plans for claims incurred January 2007 through December 2007 and paid through the end of March 2008. Exhibit 17-B provides a summary of the savings by plan along with a pie chart that provides the percentage of savings in each category combining all plans.

For the **Standard Plan**, WPS paid 68.0% of submitted charges on behalf of the plan. Of the 32.0% savings, 18.0% came from pricing cutbacks from the network providers. Another 7.9% of savings was received from the rejection of duplicate charges or charges that were not eligible. Another 3.4% of savings was received by rejection of non-covered services. The Standard Plan also had 1.8% of charges paid by the members with deductibles, coinsurance and copays. The savings due to third party liability is small at this time but these types of recoveries can be long term and may take several years to be completed.

For the **SMP Plan**, WPS paid 73.3% of submitted charges on behalf of the plan. Of the 26.7% savings, 13.8% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. Another 10.9% was received from pricing cutbacks from network providers. In comparison to the Standard Plan, the SMP Plan members contributed only 0.4% in out-of-pocket costs. The SMP Plan does have some out-of-pocket costs in the form of ER Copays and coinsurance on DME and Outpatient Psychiatric Visits. The total seen in the copayment segment is not just ER copays but also encompasses coinsurance amounts that do not apply to the annual out-of-pocket maximum for a member.

For the **Medicare Plus $1M Plan**, WPS paid 7.0% of submitted charges on behalf of the plan. Payments made by Medicare have an overwhelming impact on savings by accounting for 80.4% of the submitted charges. The second highest savings, 11.7%, came from the rejection of duplicate or non-eligible charges. This percentage has decreased from 17.3% in 2006. The decrease is the result of a WPS Claims Department provider education initiative regarding optimal methods of claim submission.

As seen in the pie chart in Exhibit 17-B, the total payment made by WPS for all plan types in 2006 was 17.8% of submitted charges. With the Medicare population's impact, 66.4% of the savings was provided by Medicare, followed by 11.0% in rejections for duplicates and non-eligible services and 3.1% in pricing cutback.

Exhibit 17-A

STATE EMPLOYEE TRUST FUNDS

Medical Claim Savings Analysis

Incurred January 2007 - December 2007 Paid Through March 2008

Category	STANDARD		SMP		MEDICARE PLUS ONE MILLION	
	$ Amount	% of Total	$ Amount	% of Total	$ Amount	% of Total
Submitted Charges	**$44,132,114.12**	**100.0%**	**$3,124,686.06**	**100.0%**	**$222,261,502.13**	**100.0%**
Duplicates/Not Eligible	**$3,480,386.69**	**7.9%**	**$168,402.61**	**5.4%**	**$25,894,610.62**	**11.7%**
Pricing Cutbacks	**$7,956,120.61**	**18.0%**	**$340,529.85**	**10.9%**		
Out-of-Pocket						
Deductible	$504,241.08	1.1%	$0.00	0.0%	$0.00	0.0%
Coinsurance	$286,282.68	0.6%	$1,954.86	0.1%	$61,952.83	0.0%
Copayments	$300.00	0.0%	$11,317.20	0.4%	$499.00	0.0%
Total	**$790,823.76**	**1.8%**	**$13,272.06**	**0.4%**	**$62,451.83**	**0.0%**
Not Covered						
Medical Necessity	$214,787.33	0.5%	$14,142.66	0.5%	$29,178.96	0.0%
Inappropriate Provider	$35,455.31	0.1%	$0.00	0.0%	$5,901.70	0.0%
Benefit Maximum	$99,461.50	0.2%	$6,630.40	0.2%	$507,651.34	0.2%
Experimental/Fertility	$70,017.37	0.2%	$117.00	0.0%	$21,147.00	0.0%
Dental	$32,482.45	0.1%	$2,760.00	0.1%	$17,404.06	0.0%
Custodial	$41.56	0.0%	$0.00	0.0%	$519,621.54	0.2%
Code Review	$543,159.64	1.2%	$56,989.04	1.8%	$70,988.32	0.0%
Contact Lens/Hearing Aid	$21,193.42	0.0%	$3,333.88	0.1%	$95,939.26	0.0%
Drugs	$0.00	0.0%	$0.00	0.0%	$35,455.16	0.0%
No Referral	$0.00	0.0%	$142,368.22	4.6%	$0.00	0.0%
All Other	$482,669.44	1.1%	$36,152.53	1.2%	$606,631.44	0.3%
Total	**$1,499,268.02**	**3.4%**	**$262,493.73**	**8.4%**	**$1,909,918.78**	**0.9%**
Third Party Liability						
Workers Compensation	$19,889.39	0.0%	$30,280.97	1.0%	$65,272.53	0.0%
Subrogation	$10,873.71	0.0%	$0.00	0.0%	$11,933.17	0.0%
Coordination of Benefits	$157,978.60	0.4%	$18,231.62	0.6%	$5,982.83	0.0%
Total	**$188,741.70**	**0.4%**	**$48,512.59**	**1.6%**	**$83,188.53**	**0.0%**
Medicare	**$188,766.74**	**0.4%**	**$0.00**	**0.0%**	**$178,690,890.89**	**80.4%**
Payments	**$30,028,006.60**	**68.0%**	**$2,291,475.22**	**73.3%**	**$15,620,441.48**	**7.0%**

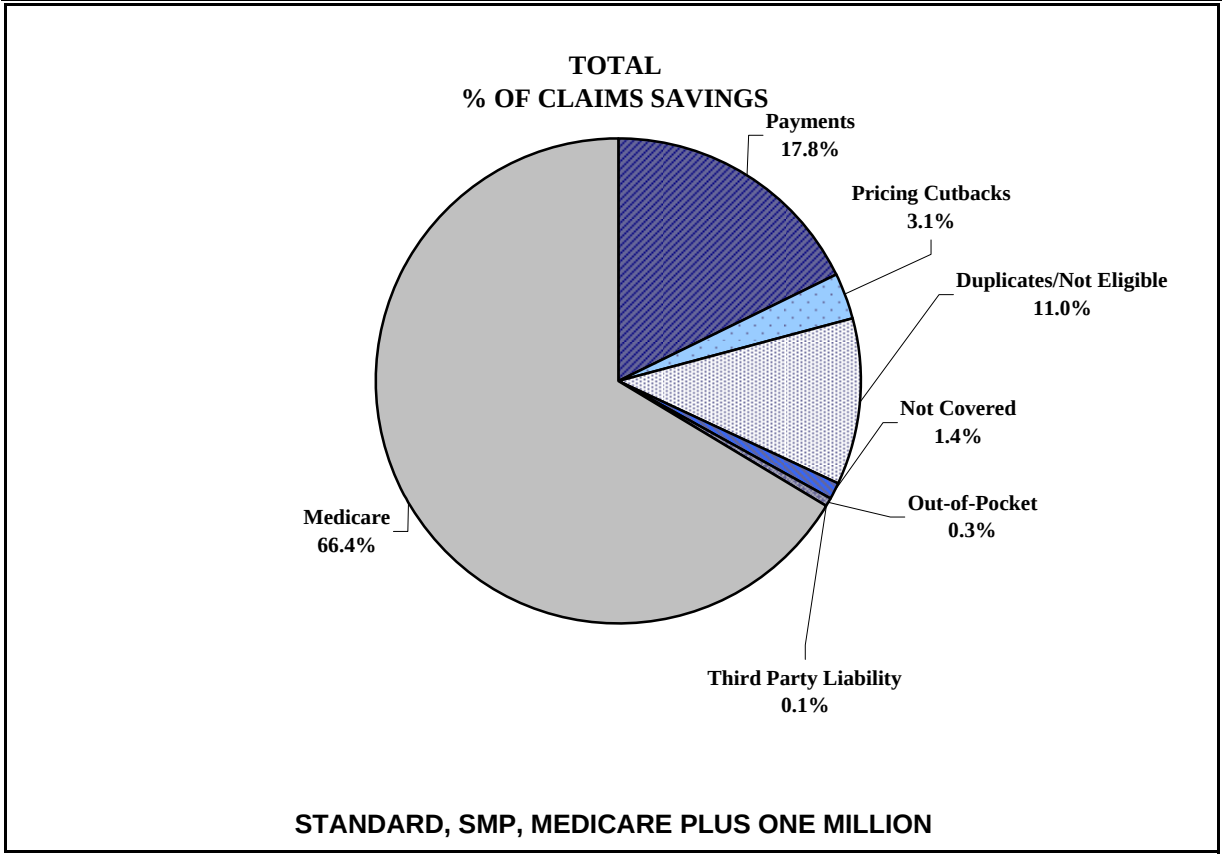
Exhibit 17-B

STATE EMPLOYEE TRUST FUNDS

Medical Claim Savings Analysis Summary

Incurred January 2007 - December 2007 Paid Through March 2008

	STANDARD		SMP		MEDICARE PLUS ONE MILLION	
	$ Amount	% of Total	$ Amount	% of Total	$ Amount	% of Total
Payments	$30,028,006.60	68.0%	$2,291,475.22	73.3%	$15,620,441.48	7.0%
Pricing Cutbacks	$7,956,120.61	18.0%	$340,529.85	10.9%		
Duplicates/Not Eligible	$3,480,386.69	7.9%	$168,402.61	5.4%	$25,894,610.62	11.7%
Not Covered	$1,499,268.02	3.4%	$262,493.73	8.4%	$1,909,918.78	0.9%
Out-of-Pocket	$790,823.76	1.8%	$13,272.06	0.4%	$62,451.83	0.0%
Third Party Liability	$188,741.70	0.4%	$48,512.59	1.6%	$83,188.53	0.0%
Medicare	$188,766.74	0.4%	$0.00	0.0%	$178,690,890.89	80.4%



WPS HEALTH INSURANCE

State of Wisconsin

Section 2: Wisconsin Public Employers

Insuring **Wisconsin's** Health *Since 1946*

Wisconsin Public Employers

Executive Summary

Member / Demographic Data

Total enrollment was 404 members as of January 2008, up 6 from the 398 members in the plan in December 2007. Membership remained quite stable despite the SMP region reduction from 12 counties to 9 as of January 2008.

The **Standard Plan** membership is much older than the normative distribution with 71.6% of membership over the age of 50 compared to the benchmark of 25.6%. 67.9% of the Standard Plan participants live within Wisconsin.

The ages of the **SMP Plan** members by comparison are younger than our benchmark. The SMP Plan membership is entirely within Wisconsin and in the more rural areas with a majority of the population in the northern fringe of Wisconsin. For the SMP Plan all of the membership is within Marinette County. As of January 2008, the SMP plan is no longer available in Marinette County, and in total will be available in only 9 counties.

Claims Data

Standard Plan

The Standard Plan has seen a 23.2% decrease in medical claim costs between 2006 and 2007. The Standard Plan was 3.9% below the benchmark in 2007. The small population of the Standard Plan results in large variances in claim costs from year to year which happened to be better than expected in 2007.

The Standard Plan did not have any members exceed $100,000 in claim costs. The Standard Plan members pay 6.0% of their own medical claims as compared to the benchmark of 6.7%.

WPS paid 76.2% of submitted charges on behalf of the plan.

SMP Plan

For the SMP Plan, the year over year medical PMPM trend was 5.0%. The SMP Plan was 22.1% above the benchmark in 2007. The small population of the SMP Plan results in large variances in claim cost from year to year.

The SMP Plan did not have any members exceed $100,000 in claim costs. The SMP Plan members pay 1% towards their own medical claims (in the form of cost sharing), unlike the members of most large groups who pay an average of about 9.3% of their medical claims.

WPS paid 73.1% of submitted charges on behalf of the plan.

Medicare Carve-out Plan

The Medicare Carve-out Plan has seen stable results over the last 2 years. The year over year medical PMPM trend from 2006 to 2007 was 3.6%.

WPS paid 5.6% of submitted charges on behalf of the plan. 76.7% of the charges were paid by Medicare.

Provider Data

For the **Standard Plan**, the top 20 facilities provide 91.6% of the total facility charges for the plan. 52.7% of professional charges are from the top 20 providers.

For the **SMP Plan**, the top 7 facilities provide 100.0% of the total facility charges for the plan. 88.6% of the paid claims are from the top 20 professional providers. Dickinson County Memorial Hospital in Iron Mountain, Michigan was the largest provider of Facility and Professional services.

Benchmarks

The benchmarks used in this report are derived from the experience of WPS large group and self funded business. In general, these groups are a combination of private and public employers, ranging in size from 51 employees to 5,000. All groups have their primary location and the majority of their population in Wisconsin. Only groups with a full year of experience with WPS were included to avoid any biases resulting from seasonality.

Demographic benchmarks are based on calendar year 2007 data. For Medicare classes, demographic benchmarks are based on comparable WPS Medicare enrollment as appropriate.

Claim cost benchmarks are also based on calendar year 2007 data. To make the claim benchmarks more meaningful, they have been adjusted for demographic differences between the specific population profiled in each report and the population in the WPS benchmark. For example, an older population may be expected to have higher prescription drug costs but lower maternity costs. Unless otherwise specified, each claim based benchmark has had such an adjustment made, including not only PMPM costs but days/1000 and cost/day. The factors that go into each adjustment are unique to the particular claim-based statistic. Claim benchmarks are not adjusted, however, for plan benefit differences between the average represented in the WPS benchmark and the specific reported ETF class.

Wisconsin Public Employers

Group Demographics

Monthly Membership

The Monthly Membership report in Exhibit 1-B shows monthly membership and incurred claims for the Standard, SMP and Medicare Carve-out plans from January 2006 through December 2007

Enrollment on the **Standard Plan** averaged 106 members per month in 2006 and decreased to an average of 68 in 2007. The membership over the course of the year remained fairly stable with increases beginning in September of each year.

SMP Plan enrollment averaged 201 members per month in 2006 and decreased to an average of 44 per month in 2007. This reduction is the result of a reduced service area in which the plan is available, dropping from 27 counties in 2006 to 12 counties in 2007. The membership remained very stable within each year with very little seasonal fluctuation

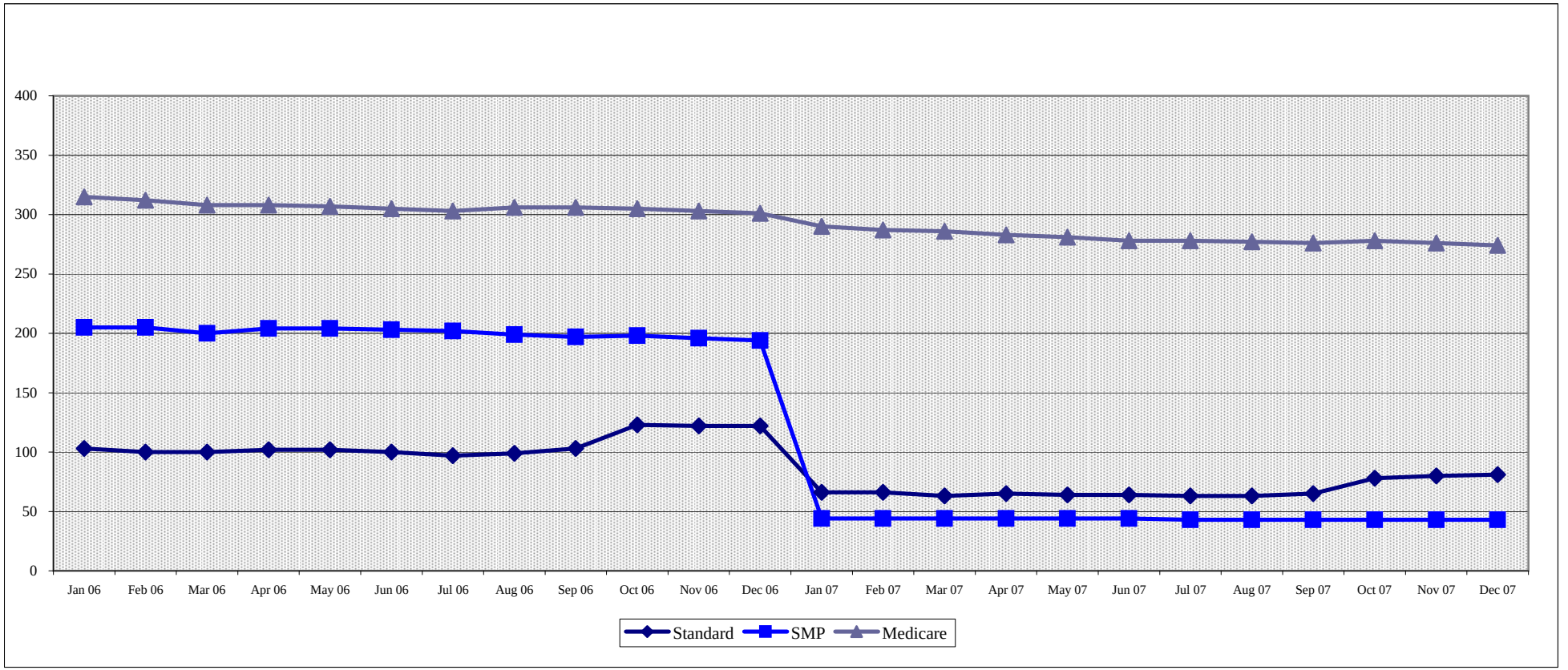
The **Medicare Carve-out Plan** enrollment averaged 307 members per month in 2006 and decreased to 280 members per month in 2007. The membership declined gradually over the course of the two years, beginning with 315 members in January 2006 and ending at 274 in December of 2007, a 13% reduction in membership during the 2 years.

WISCONSIN PUBLIC EMPLOYERS

Monthly Membership

January 2006 through December 2007

Exhibit 1-B



	EFFECTIVE MONTH																							
	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
Standard	103	100	100	102	102	100	97	99	103	123	122	122	66	66	63	65	64	64	63	63	65	78	80	81
SMP	205	205	200	204	204	203	202	199	197	198	196	194	44	44	44	44	44	44	43	43	43	43	43	43
Medicare	315	312	308	308	307	305	303	306	306	305	303	301	290	287	286	283	281	278	278	277	276	278	276	274

Enrollment by Plan

The Enrollment by Plan report shown in Exhibit 2-B shows the December 2007 membership for the Standard, SMP and Medicare Plus $1M Plans at the class level. For each class, member average age and gender distribution is shown. The age/gender factor is included as an index intended to represent expected plan cost based on the age and gender of each member, without regard to plan design, health, etc. The age/gender factor is not shown for the Medicare Carve-out Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

Exhibit 2-B

WISCONSIN PUBLIC EMPLOYERS
Enrollment by Plan
December 2007

Plan	Class	# of Members	Average Member Age	Member Gender Distribution Female	Member Age/ Gender Factor
Classic Standard	Milwaukee	18	55.7	55.6%	2.197
	Waukesha	1	52.0	0.0%	1.594
	Dane	10	47.6	50.0%	1.883
	Rest of State	32	50.3	50.0%	1.905
	Annuitants	10	59.5	70.0%	2.435
	Continuation	0	0.0	0.0%	0.000
	Medicare	273	75.7	58.2%	N/A
	Subtotal	**344**	**70.9**	**57.3%**	**2.046**
Deductible Classic Standard	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	0	0.0	0.0%	0.000
	Dane	0	0.0	0.0%	0.000
	Rest of State	3	34.0	33.3%	0.946
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	1	72.0	100.0%	N/A
	Subtotal	**4**	**43.5**	**50.0%**	**0.946**
Standard Preferred	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	0	0.0	0.0%	0.000
	Dane	0	0.0	0.0%	0.000
	Rest of State	3	55.3	66.7%	2.058
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	0	0.0	0.0%	N/A
	Subtotal	**3**	**55.3**	**66.7%**	**2.058**
Deductible Standard Preferred	Milwaukee	0	0.0	0.0%	0.000
	Waukesha	0	0.0	0.0%	0.000
	Dane	0	0.0	0.0%	0.000
	Rest of State	4	33.8	50.0%	1.277
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Medicare	0	0.0	0.0%	N/A
	Subtotal	**4**	**33.8**	**50.0%**	**1.277**
SMP	Local	43	32.5	44.2%	1.046
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Subtotal	**43**	**32.5**	**44.2%**	**1.046**
Deductible SMP	Local	0	0.0	0.0%	0.000
	Annuitants	0	0.0	0.0%	0.000
	Continuation	0	0.0	0.0%	0.000
	Subtotal	**0**	**0.0**	**0.0%**	**0.000**
WPE Grand Total		**398**	**66.0**	**55.8%**	**N/A**

Member Census Grids

The Member Census Grid breaks down the December 2007 membership into age and gender categories for the Standard, SMP and Medicare Carve-out Plans. The Standard and SMP distributions are compared to a benchmark distribution based on WPS large group business as described in the Executive Summary. The benchmark distribution for the Medicare Carve-out Plan is based on WPS Medicare Carve-out business.

Standard Plan

The Standard Plan membership shown in Exhibit 3-D appears to be much older than the normative distribution with 71.6% of membership over the age of 50 compared to the benchmark of 25.6%. Older members tend to seek more medical care and tend to select a broader panel of providers for that care. Since the Standard Plan has a broader panel of providers, this causes the average age to be higher.

Also contributing to the older than expected membership is the smaller than expected population of children with only 7.4% of the membership under the age of 20 compared to the benchmark of 29.7%. The Standard Plan also has a slightly higher than normal population of females with 53.1% female as compared to the benchmark of 51.8%.

SMP Plan

The SMP Plan membership shown in Exhibit 3-E by comparison is on average younger than our benchmark. The SMP distribution is significantly lower than the benchmark at ages 55 and older.

Medicare Carve-out Plan

The Medicare Carve-out Plan membership is shown in Exhibit 3-F. The population is in line with the benchmark distribution.

Exhibit 3-D

WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - Standard
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	1	1.2%	14.4%
20 - 24	1	1.2%	3.7%
25 - 29	1	1.2%	3.5%
30 - 34	2	2.5%	3.3%
35 - 39	1	1.2%	3.9%
40 - 44	0	0.0%	4.5%
45 - 49	6	7.4%	5.0%
50 - 54	11	13.6%	5.0%
55 - 59	8	9.9%	4.3%
60 - 64	11	13.6%	2.7%
65 +	1	1.2%	1.5%
Total	**43**	**53.1%**	**51.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	5	6.2%	15.3%
20 - 24	0	0.0%	3.3%
25 - 29	0	0.0%	2.7%
30 - 34	1	1.2%	3.0%
35 - 39	0	0.0%	3.5%
40 - 44	5	6.2%	4.0%
45 - 49	0	0.0%	4.3%
50 - 54	3	3.7%	4.2%
55 - 59	10	12.3%	3.8%
60 - 64	11	13.6%	2.6%
65 +	3	3.7%	1.5%
Total	**38**	**46.9%**	**48.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	6	7.4%	29.7%
20 - 24	1	1.2%	7.0%
25 - 29	1	1.2%	6.2%
30 - 34	3	3.7%	6.3%
35 - 39	1	1.2%	7.4%
40 - 44	5	6.2%	8.5%
45 - 49	6	7.4%	9.3%
50 - 54	14	17.3%	9.2%
55 - 59	18	22.2%	8.1%
60 - 64	22	27.2%	5.3%
65 +	4	4.9%	3.0%
Total	**81**	**100.0%**	**100.0%**

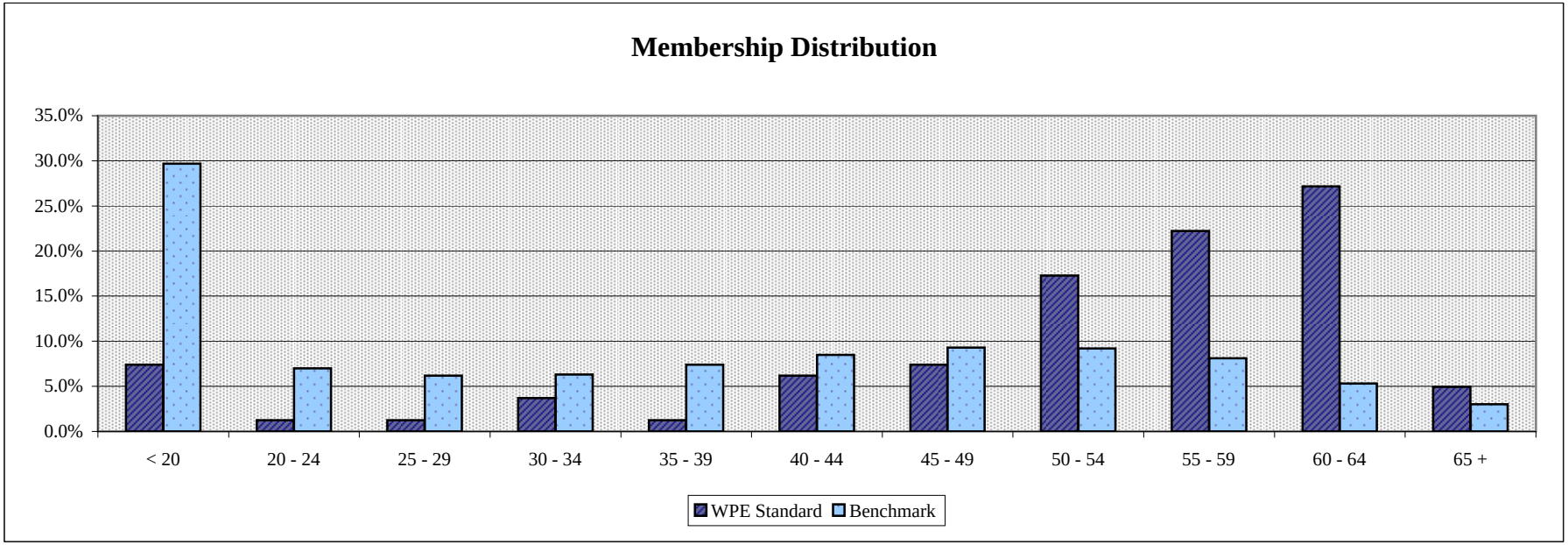


Exhibit 3-E

WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - SMP
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 20	4	9.3%	14.4%
20 - 24	3	7.0%	3.7%
25 - 29	0	0.0%	3.5%
30 - 34	1	2.3%	3.3%
35 - 39	4	9.3%	3.9%
40 - 44	0	0.0%	4.5%
45 - 49	4	9.3%	5.0%
50 - 54	1	2.3%	5.0%
55 - 59	2	4.7%	4.3%
60 - 64	0	0.0%	2.7%
65 +	0	0.0%	1.5%
Total	**19**	**44.2%**	**51.8%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 20	9	20.9%	15.3%
20 - 24	2	4.7%	3.3%
25 - 29	0	0.0%	2.7%
30 - 34	1	2.3%	3.0%
35 - 39	1	2.3%	3.5%
40 - 44	4	9.3%	4.0%
45 - 49	2	4.7%	4.3%
50 - 54	4	9.3%	4.2%
55 - 59	0	0.0%	3.8%
60 - 64	1	2.3%	2.6%
65 +	0	0.0%	1.5%
Total	**24**	**55.8%**	**48.2%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 20	13	30.2%	29.7%
20 - 24	5	11.6%	7.0%
25 - 29	0	0.0%	6.2%
30 - 34	2	4.7%	6.3%
35 - 39	5	11.6%	7.4%
40 - 44	4	9.3%	8.5%
45 - 49	6	14.0%	9.3%
50 - 54	5	11.6%	9.2%
55 - 59	2	4.7%	8.1%
60 - 64	1	2.3%	5.3%
65 +	0	0.0%	3.0%
Total	**43**	**100.0%**	**100.0%**

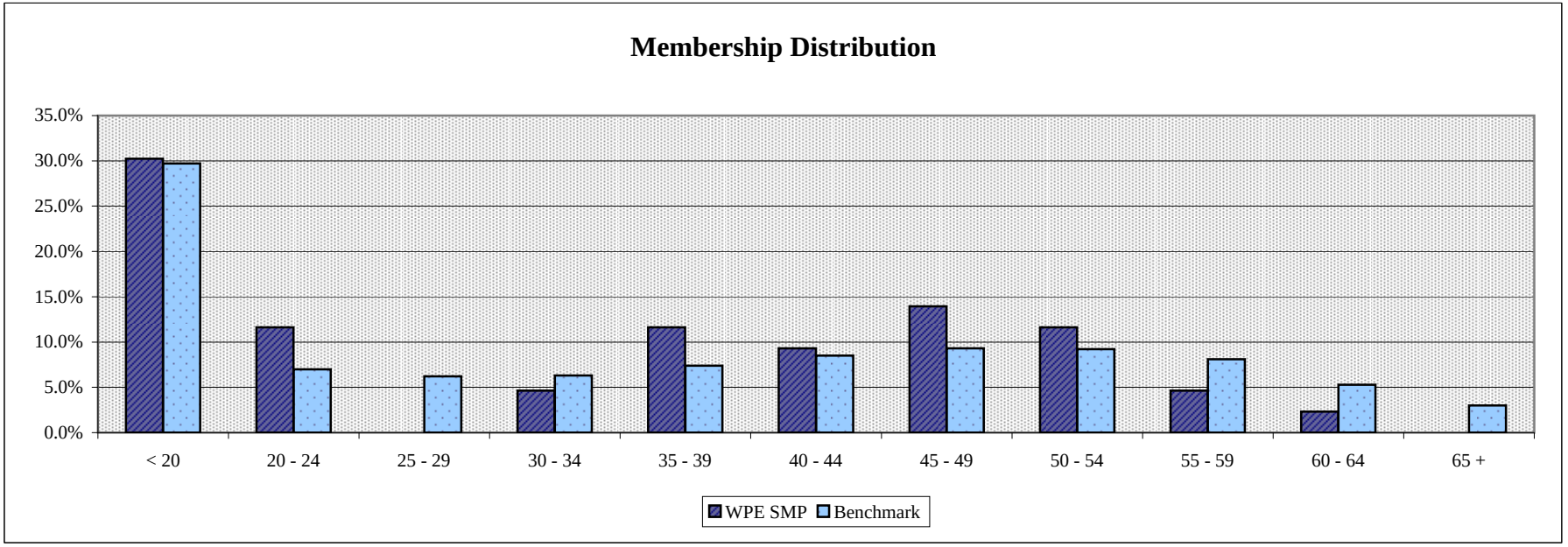


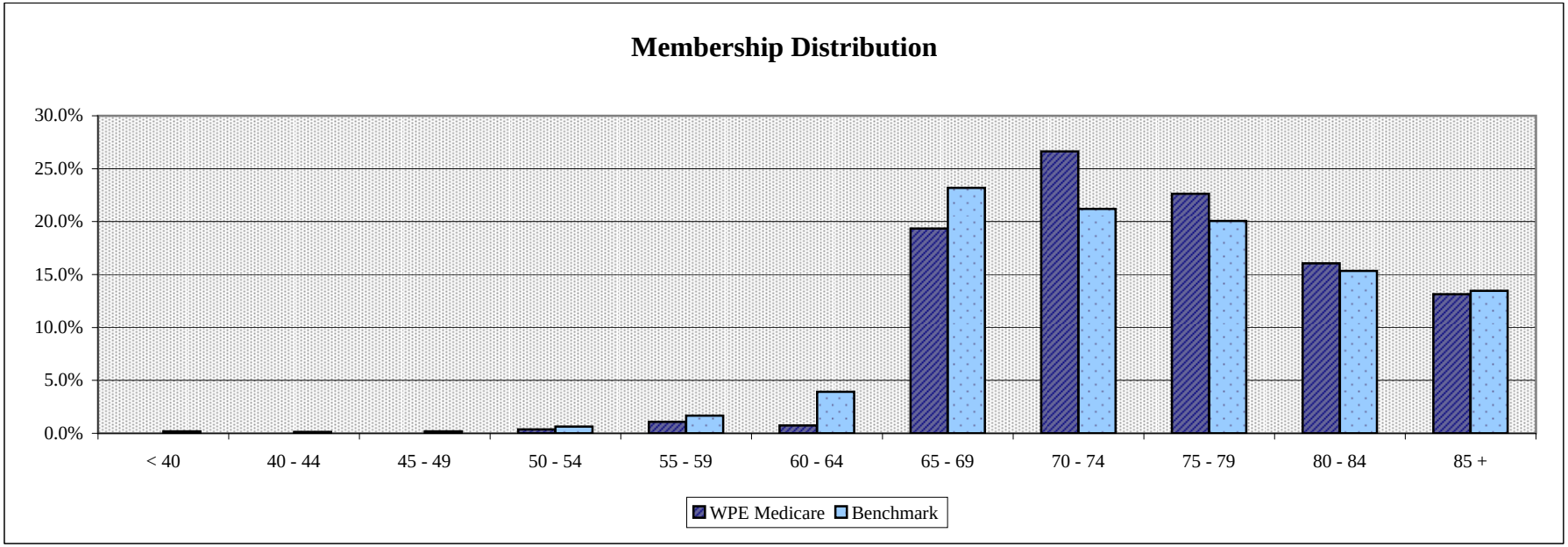
Exhibit 3-F

WISCONSIN PUBLIC EMPLOYERS
Member Census Grid - Medicare
December 2007

FEMALE			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.1%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.1%
50 - 54	1	0.4%	0.4%
55 - 59	3	1.1%	1.0%
60 - 64	2	0.7%	2.4%
65 - 69	29	10.6%	13.4%
70 - 74	42	15.3%	12.1%
75 - 79	36	13.1%	11.8%
80 - 84	23	8.4%	9.9%
85 +	24	8.8%	9.9%
Total	**160**	**58.4%**	**61.1%**

MALE			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.1%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.1%
50 - 54	0	0.0%	0.3%
55 - 59	0	0.0%	0.7%
60 - 64	0	0.0%	1.5%
65 - 69	24	8.8%	9.8%
70 - 74	31	11.3%	9.1%
75 - 79	26	9.5%	8.2%
80 - 84	21	7.7%	5.5%
85 +	12	4.4%	3.6%
Total	**114**	**41.6%**	**38.9%**

TOTAL			
Age Band	# of Members	% of Total	Benchmark
< 40	0	0.0%	0.2%
40 - 44	0	0.0%	0.1%
45 - 49	0	0.0%	0.2%
50 - 54	1	0.4%	0.6%
55 - 59	3	1.1%	1.7%
60 - 64	2	0.7%	3.9%
65 - 69	53	19.3%	23.2%
70 - 74	73	26.6%	21.2%
75 - 79	62	22.6%	20.1%
80 - 84	44	16.1%	15.4%
85 +	36	13.1%	13.5%
Total	**274**	**100.0%**	**100.0%**



Wisconsin Enrollment

The Wisconsin Enrollment map in Exhibit 4-C visually shows how the membership for the Standard and SMP plans are dispersed throughout Wisconsin. The map shows enrollment as of December 1, 2007. Each of the dots represents one address. Exhibit 4-D shows the same information numerically.

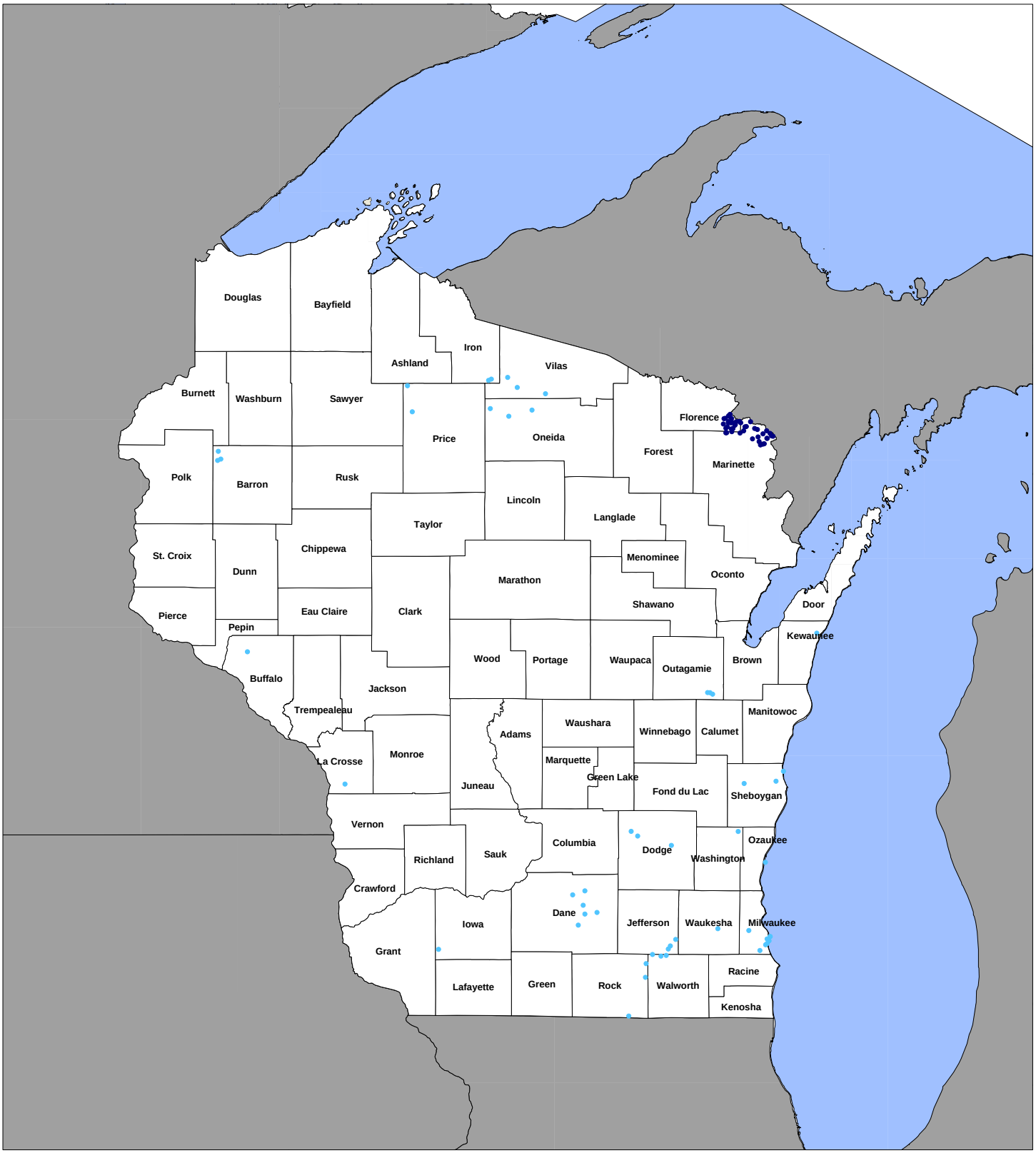
67.9% of the **Standard Plan** participants live within Wisconsin. The Standard Plan population is spread out among 21 counties in Wisconsin with 9.9% of the population living in Milwaukee County, 7.4% in Dane County, and 4.9% each in Jefferson, Price, Vilas and Walworth Counties.

The **SMP Plan** membership in comparison is entirely within Marinette County. You may notice on exhibit 4-C that some of the membership looks to be in Florence County. This is due to a few zip codes that overlap county lines. In 2007 the SMP Plan was only available in 12 counties down from 27 county region 2006. As of January 2008, the SMP plan is no longer available in Marinette County, and in total will be available in only 9 counties.

WISCONSIN PUBLIC EMPLOYERS

Exhibit 4-C

Enrollment By County
December 2007



Standard

SMP

WISCONSIN PUBLIC EMPLOYERS

Enrollment By County

December 2007

Exhibit 4-D

County	STANDARD # of Members	STANDARD % of Members	SMP # of Members	SMP % of Members
ADAMS	0	0.0%	0	0.0%
ASHLAND	0	0.0%	0	0.0%
BARRON	3	3.7%	0	0.0%
BAYFIELD	0	0.0%	0	0.0%
BROWN	0	0.0%	0	0.0%
BUFFALO	0	0.0%	0	0.0%
BURNETT	0	0.0%	0	0.0%
CALUMET	0	0.0%	0	0.0%
CHIPPEWA	0	0.0%	0	0.0%
CLARK	0	0.0%	0	0.0%
COLUMBIA	0	0.0%	0	0.0%
CRAWFORD	0	0.0%	0	0.0%
DANE	6	7.4%	0	0.0%
DODGE	3	3.7%	0	0.0%
DOOR	0	0.0%	0	0.0%
DOUGLAS	0	0.0%	0	0.0%
DUNN	0	0.0%	0	0.0%
EAU CLAIRE	0	0.0%	0	0.0%
FLORENCE	0	0.0%	0	0.0%
FOND DU LAC	0	0.0%	0	0.0%
FOREST	0	0.0%	0	0.0%
GRANT	1	1.2%	0	0.0%
GREEN	0	0.0%	0	0.0%
GREEN LAKE	0	0.0%	0	0.0%
IOWA	0	0.0%	0	0.0%
IRON	0	0.0%	0	0.0%
JACKSON	0	0.0%	0	0.0%
JEFFERSON	4	4.9%	0	0.0%
JUNEAU	0	0.0%	0	0.0%
KENOSHA	0	0.0%	0	0.0%
KEWAUNEE	1	1.2%	0	0.0%
LACROSSE	1	1.2%	0	0.0%
LAFAYETTE	0	0.0%	0	0.0%
LANGLADE	0	0.0%	0	0.0%
LINCOLN	0	0.0%	0	0.0%
MANITOWOC	0	0.0%	0	0.0%
MARATHON	0	0.0%	0	0.0%
MARINETTE	0	0.0%	43	100.0%
MARQUETTE	0	0.0%	0	0.0%
MENOMINEE	0	0.0%	0	0.0%
MILWAUKEE	8	9.9%	0	0.0%
MONROE	0	0.0%	0	0.0%
OCONTO	0	0.0%	0	0.0%
ONEIDA	2	2.5%	0	0.0%
OUTAGAMIE	3	3.7%	0	0.0%
OZAUKEE	1	1.2%	0	0.0%
PEPIN	1	1.2%	0	0.0%
PIERCE	0	0.0%	0	0.0%
POLK	0	0.0%	0	0.0%
PORTAGE	0	0.0%	0	0.0%
PRICE	4	4.9%	0	0.0%
RACINE	0	0.0%	0	0.0%
RICHLAND	0	0.0%	0	0.0%
ROCK	1	1.2%	0	0.0%
RUSK	0	0.0%	0	0.0%
SAUK	0	0.0%	0	0.0%
SAWYER	0	0.0%	0	0.0%
SHAWANO	2	2.5%	0	0.0%
SHEBOYGAN	3	3.7%	0	0.0%
ST CROIX	0	0.0%	0	0.0%
TAYLOR	0	0.0%	0	0.0%
TREMPEALEAU	1	1.2%	0	0.0%
VERNON	0	0.0%	0	0.0%
VILAS	4	4.9%	0	0.0%
WALWORTH	4	4.9%	0	0.0%
WASHBURN	0	0.0%	0	0.0%
WASHINGTON	1	1.2%	0	0.0%
WAUKESHA	1	1.2%	0	0.0%
WAUPACA	0	0.0%	0	0.0%
WAUSHARA	0	0.0%	0	0.0%
WINNEBAGO	0	0.0%	0	0.0%
WOOD	0	0.0%	0	0.0%
OUT OF STATE	26	32.1%	0	0.0%
Totals	**81**	**100.0%**	**43**	**100.0%**

Out of State Enrollment

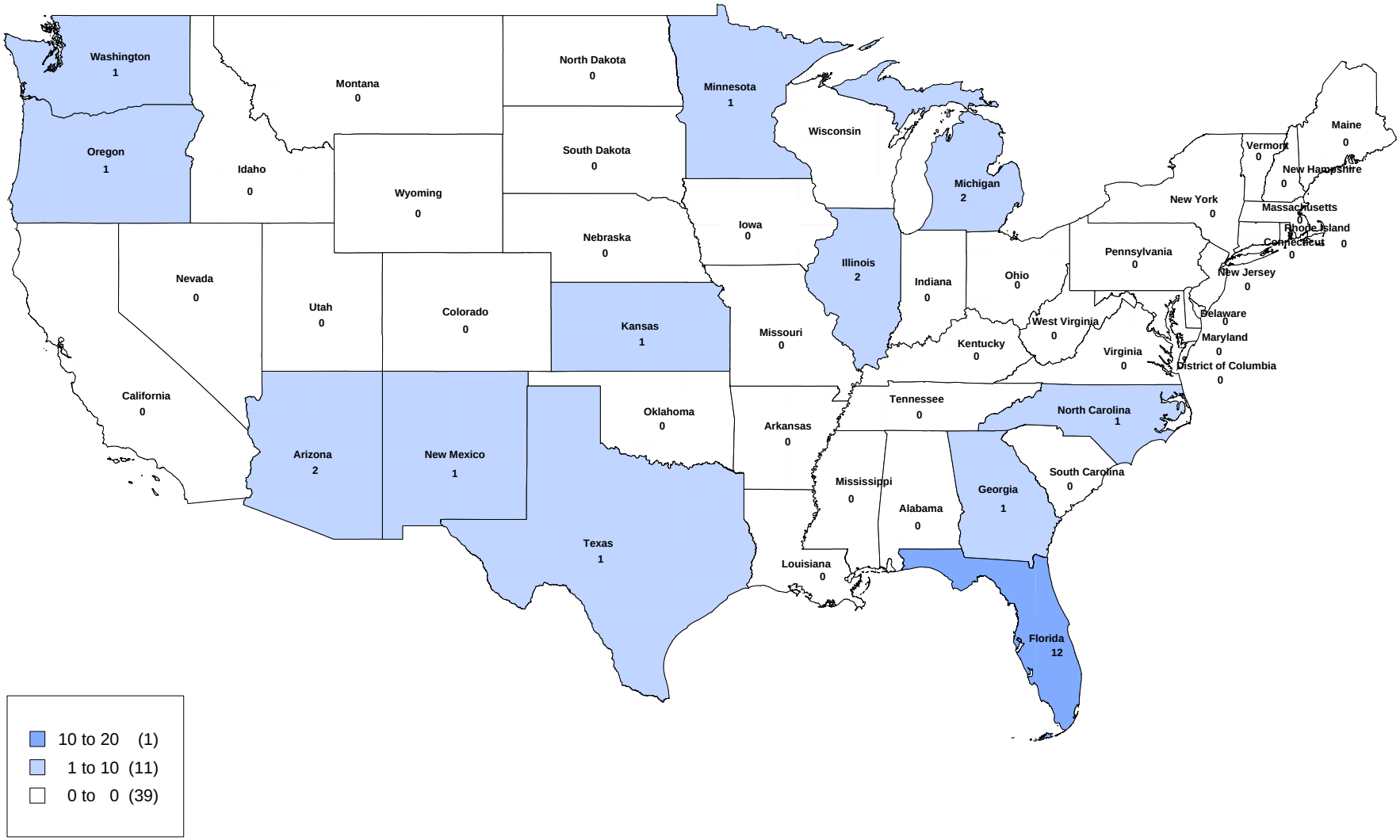
The United States Enrollment Map in Exhibit 5-C visually depicts how the enrollment in the Standard and SMP plans are spread throughout the United States. The out of state enrollment is based on the member's address as of December 1, 2007 and could change as members relocate. The map displays the number of Standard and SMP plan members living in each state along with a shading scheme in which higher population areas are represented with increasingly darker shading. Exhibit 5-D shows the same information numerically.

The **Standard Plan** has 32.1% of the population living outside the state of Wisconsin with the membership dispersed over 12 states. 69.2% of the out of state membership lives in the sunbelt.

The **SMP Plan** in comparison has does not have members residing outside of Wisconsin.

WISCONSIN PUBLIC EMPLOYERS
Out of State Enrollment
December 2007

Exhibit 5-C



WISCONSIN PUBLIC EMPLOYERS

Exhibit 5-D

Out of State Enrollment

December 2007

State	STANDARD # of Members	STANDARD % of Members	SMP # of Members	SMP % of Members
ALABAMA	0	0.0%	0	0.0%
ALASKA	0	0.0%	0	0.0%
ARIZONA	2	7.7%	0	0.0%
ARKANSAS	0	0.0%	0	0.0%
CALIFORNIA	0	0.0%	0	0.0%
COLORADO	0	0.0%	0	0.0%
CONNECTICUT	0	0.0%	0	0.0%
DELAWARE	0	0.0%	0	0.0%
FLORIDA	12	46.2%	0	0.0%
GEORGIA	1	3.8%	0	0.0%
HAWAII	0	0.0%	0	0.0%
IDAHO	0	0.0%	0	0.0%
ILLINOIS	2	7.7%	0	0.0%
INDIANA	0	0.0%	0	0.0%
IOWA	0	0.0%	0	0.0%
KANSAS	1	3.8%	0	0.0%
KENTUCKY	0	0.0%	0	0.0%
LOUISIANA	0	0.0%	0	0.0%
MAINE	0	0.0%	0	0.0%
MARYLAND	0	0.0%	0	0.0%
MASSACHUSETTS	0	0.0%	0	0.0%
MICHIGAN	2	7.7%	0	0.0%
MINNESOTA	1	3.8%	0	0.0%
MISSISSIPPI	0	0.0%	0	0.0%
MISSOURI	0	0.0%	0	0.0%
MONTANA	0	0.0%	0	0.0%
NEBRASKA	0	0.0%	0	0.0%
NEVADA	0	0.0%	0	0.0%
NEW HAMPSHIRE	0	0.0%	0	0.0%
NEW JERSEY	0	0.0%	0	0.0%
NEW MEXICO	1	3.8%	0	0.0%
NEW YORK	0	0.0%	0	0.0%
NORTH CAROLINA	1	3.8%	0	0.0%
NORTH DAKOTA	0	0.0%	0	0.0%
OHIO	0	0.0%	0	0.0%
OKLAHOMA	0	0.0%	0	0.0%
OREGON	1	3.8%	0	0.0%
PENNSYLVANIA	0	0.0%	0	0.0%
RHODE ISLAND	0	0.0%	0	0.0%
SOUTH CAROLINA	0	0.0%	0	0.0%
SOUTH DAKOTA	0	0.0%	0	0.0%
TENNESSEE	0	0.0%	0	0.0%
TEXAS	1	3.8%	0	0.0%
UTAH	0	0.0%	0	0.0%
VERMONT	0	0.0%	0	0.0%
VIRGINIA	0	0.0%	0	0.0%
WASHINGTON	1	3.8%	0	0.0%
WASHINGTON DC	0	0.0%	0	0.0%
WEST VIRGINIA	0	0.0%	0	0.0%
WYOMING	0	0.0%	0	0.0%
FOREIGN	0	0.0%	0	0.0%
Totals	**26**	**100.0%**	**0**	**0.0%**

Dual Choice Changes

The Dual Choice Enrollment Changes by Plan report in Exhibit 6-B shows the January 2008 enrollment reflecting changes that occurred during the Dual Choice Enrollment. The enrollment changes are numerical differences relative to December 2007. The change in Member / Age Gender show how much plan costs changed between 2007 and 2008 due to demographic factors. The age/gender factor is not shown for the Medicare Carve-out Plan, where coordination of benefits with Medicare has an overwhelming impact on plan cost.

Exhibit 6-B

WISCONSIN PUBLIC EMPLOYERS
Dual Choice Enrollment Changes by Plan
December 2007 to January 2008

Plan	Class	January 2008 Membership	Change in Membership from December 2007	Change in Member Age/ Gender
Classic Standard	Milwaukee	16	-2	3.80%
	Waukesha	1	0	0.00%
	Dane	13	3	-2.92%
	Rest of State	31	-1	-2.01%
	Annuitants	10	0	2.71%
	Continuation	0	0	0.00%
	Medicare	278	5	N/A
	Subtotal	**349**	**5**	**-0.38%**
Deductible Classic Standard	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	Dane	0	0	0.00%
	Rest of State	0	-3	-100.00%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Medicare	1	0	N/A
	Subtotal	**1**	**-3**	**-100.00%**
Standard Preferred	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	Dane	0	0	0.00%
	Rest of State	0	-3	-100.00%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Medicare	0	0	N/A
	Subtotal	**0**	**-3**	**-100.00%**
Deductible Standard Preferred	Milwaukee	0	0	0.00%
	Waukesha	0	0	0.00%
	Dane	0	0	0.00%
	Rest of State	4	0	0.00%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Medicare	0	0	N/A
	Subtotal	**4**	**0**	**0.00%**
SMP	Local	50	7	20.99%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Subtotal	**50**	**7**	**20.99%**
Deductible SMP	Local	0	0	0.00%
	Annuitants	0	0	0.00%
	Continuation	0	0	0.00%
	Subtotal	**0**	**0**	**0.00%**
WPE Grand Total		**404**	**6**	**N/A**

Paid Per Member Per Month Costs

The Paid Medical and Drug PMPM report in Exhibit 7-B displays the average amount paid per member each month for the Standard, SMP and Medicare Carve-out plans incurred from January 2006 through December 2007. The PMPM costs for each plan represent medical and drug claims paid through the end of March 2008.

The **Standard Plan** has seen a 23.2% reduction in total paid claim costs between 2006 and 2007. While independent trend estimates for medical claims for 2007 were 9-11%, the plan performed much better than anticipated. The standard plan had zero individualss with annual claims over $100,000. That fact has contributed to the favorable year over year claim results. The small population of the Standard Plan naturally leads to instability in the monthly claim results, as the larger spikes in claims are generally due to large claim activity that occurred in those months.

The **SMP Plan** has seen an increase in claims over the last year. The small number of members enrolled on the plan result in claim cost variance from month to month and year to year. The total paid PMPM trended up 5.0% from 2006 to 2007 which is still below trend estimates for 2007.

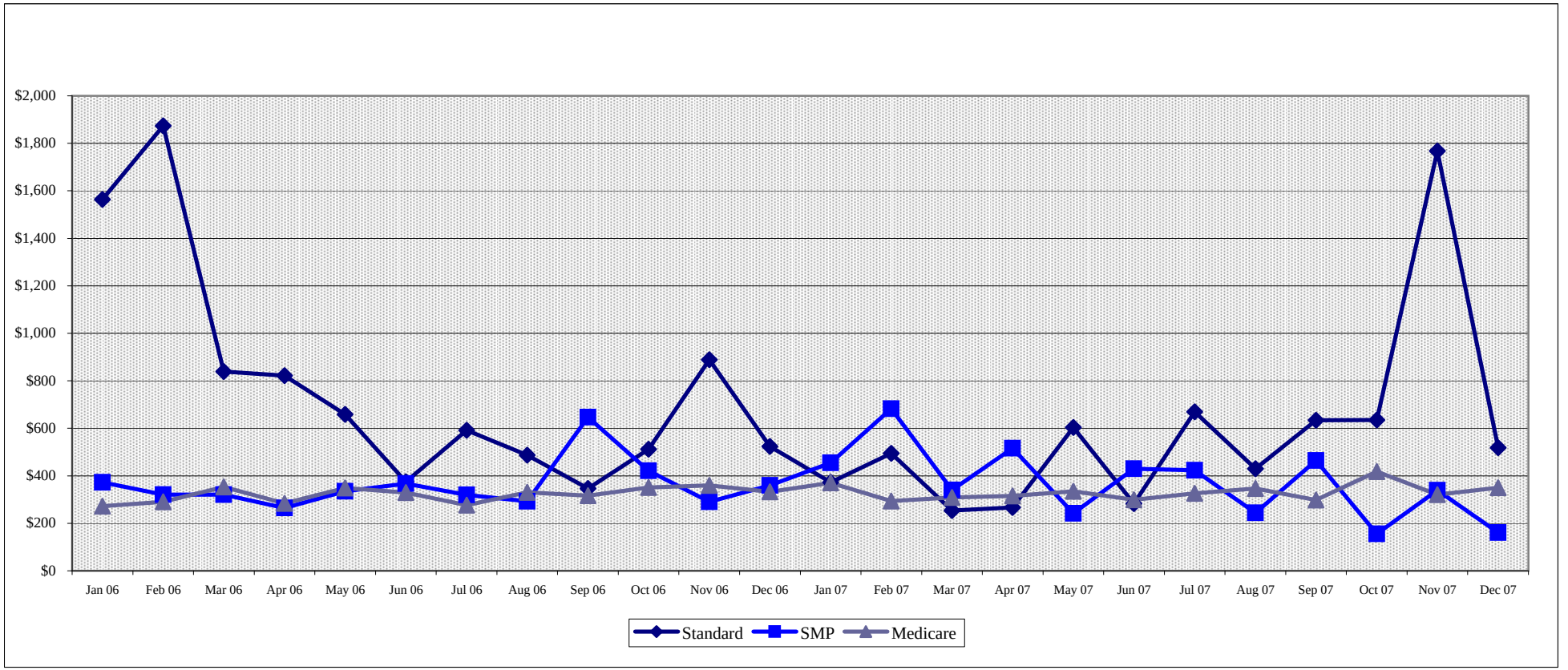
The **Medicare Carve-out Plan** has seen stable results over the last 2 years. We would expect this population to have stable results since Medicare is the primary payer. The year over year PMPM trend from 2006 to 2007 was 3.6%. We would naturally expect an increase in the medical claims each year due to the benefit changes Medicare makes annually and medical cost trend.

WISCONSIN PUBLIC EMPLOYERS

Paid Medical and Drug PMPM

Paid Through March 2008

Exhibit 7-B



	INCURRED MONTH																							
	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
Standard	$1,564.21	$1,873.31	$839.09	$822.10	$658.63	$374.33	$592.17	$487.43	$346.42	$512.41	$889.30	$523.94	$372.48	$494.97	$253.57	$266.36	$603.44	$283.29	$669.92	$429.52	$634.25	$635.14	$1,767.86	$518.39
SMP	$372.50	$320.74	$320.77	$264.36	$334.95	$367.17	$319.78	$292.80	$646.81	$421.57	$290.25	$359.79	$454.21	$682.48	$339.92	$516.63	$242.01	$429.57	$423.24	$243.64	$464.57	$155.66	$339.30	$161.04
Medicare	$272.45	$290.07	$352.95	$283.58	$349.01	$329.12	$276.86	$330.61	$316.54	$351.09	$359.22	$332.67	$369.90	$293.33	$309.01	$315.66	$334.46	$299.53	$326.66	$346.90	$297.74	$418.40	$320.88	$350.15

PMPM by Type of Service

The Total PMPM by Type of Service reports (8-F and 8-H) provide a breakdown of the PMPM by major type of service compared to the benchmark. The pie chart also provides an overview of the percentage of the PMPM each major type of service is contributing to the total PMPM plus a comparison to the benchmark. The total PMPM cost are for claims incurred January 2006 – December 2007 and paid through the end of March 2008. Exhibits 8-G and 8-I show the same actual data, but compare 2006 to 2007.

Standard Plan

The Standard Plan in Exhibit 8-F shows that the percentage breakdown by major type of service is similar to the benchmark. The facility outpatient costs make up a larger percent of the total costs while the physician costs make up less. The total PMPM cost is 3.9% below the benchmark. The inpatient facility PMPM cost is 6.9% below the benchmark and outpatient facility is 6.6% above the benchmark. The Standard Plan did not experience high cost claim activity which is directly correlated with inpatient charges. The physician PMPM cost is 7.3% below the benchmark. The drug paid PMPM cost is 12.0% below the benchmark. Lastly the other services category is 6.7% over the norm. Every $1.00 PMPM represented in the graph is equivalent to $818 in annual plan costs for the Standard plan.

Exhibit 8-G shows how claims on the Standard Plan on a PMPM basis have dropped from 2006 to 2007. Medical Claims dropped by 10.2%, most notably Facility Inpatient is down 32.9%.

SMP Plan

Exhibit 8-H shows the percentage breakdown by type of service for the SMP Plan is significantly different than the benchmark. Facility Outpatient claims comprise a much larger percentage of the total plan costs than would be expected. In total, the SMP plan is 22.1% above the benchmark. The driver of that variance is facility outpatient claims which are 133.9% higher than the benchmark. Inpatient facility PMPM cost is 39.7% below the norm and other services is 46.9% below the norm. The drug PMPM is in line with the norm, being only 1.6% lower.

Exhibit 8-I shows the SMP Plan's paid PMPM costs by type of service, comparing 2006 to 2007. Claim costs have increased 5.0% on average between the two years, which is lower than expected. However, facility inpatient claims increased by 113.8%, while all other categories decreased by over 20%.

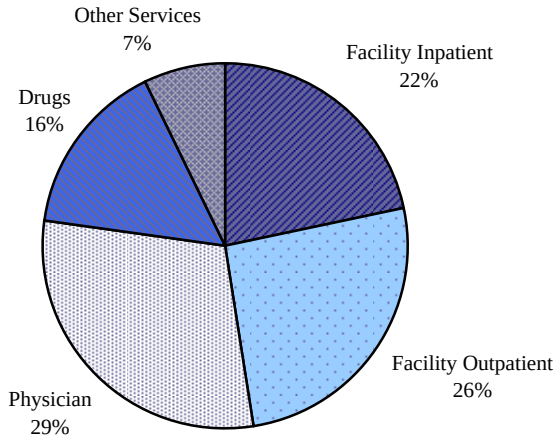
Exhibit 8-F

WISCONSIN PUBLIC EMPLOYERS

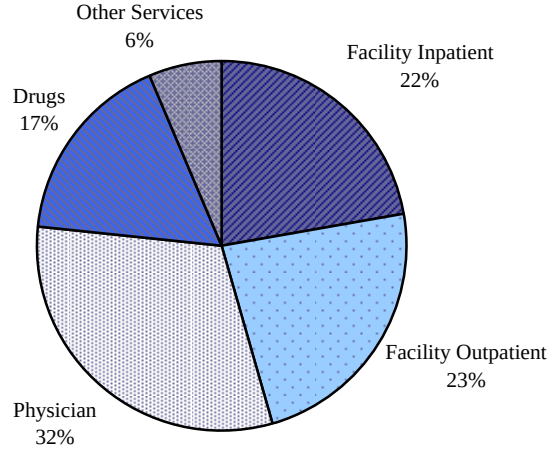
Total PMPM by Type of Service - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

Actual PMPM



Benchmark PMPM



			Difference	
	Actual	Benchmark	$	%
Facility Inpatient	**$129.91**	**$139.48**	**-$9.57**	**-6.9%**
Facility Outpatient	**$154.53**	**$144.97**	**$9.56**	**6.6%**
Physician	**$179.49**	**$193.55**	**-$14.06**	**-7.3%**
Drugs	**$93.15**	**$105.87**	**-$12.72**	**-12.0%**
Other Services	**$42.85**	**$40.16**	**$2.69**	**6.7%**
Totals	**$599.93**	**$624.03**	**-$24.10**	**-3.9%**

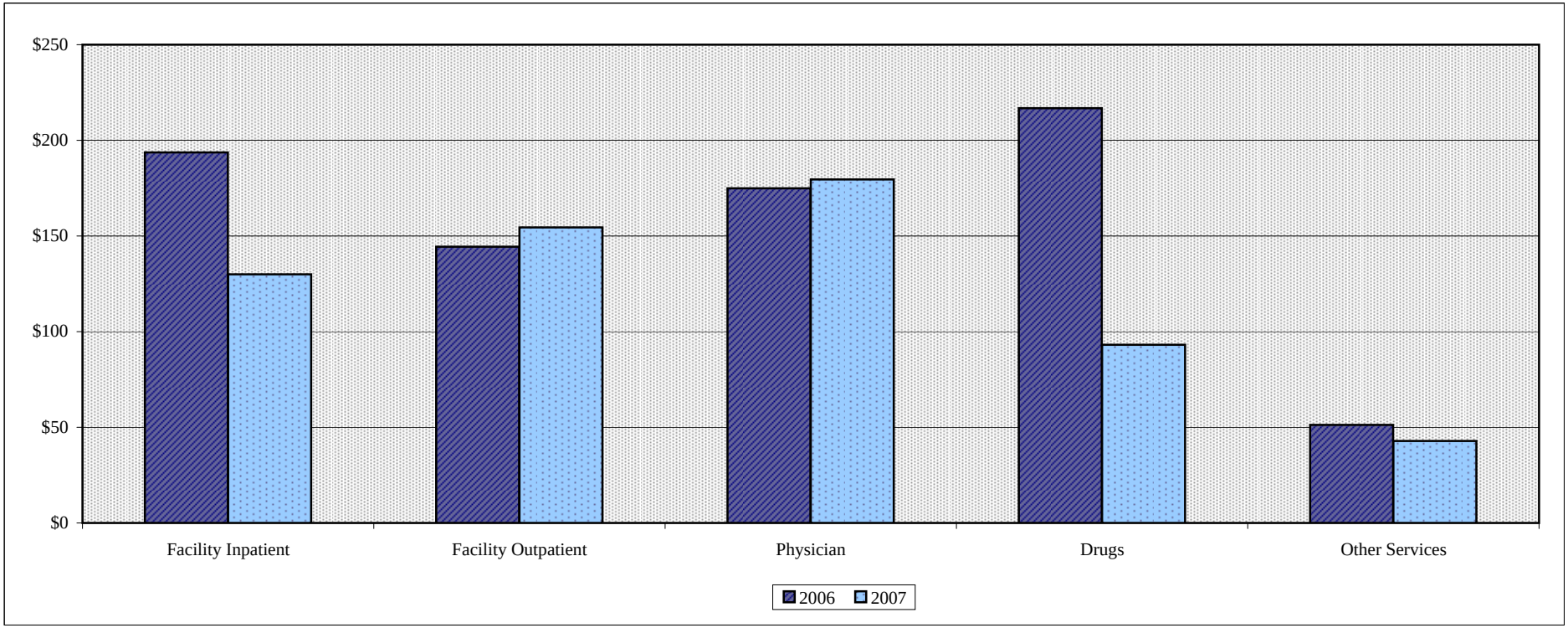
Note: Drug includes prescription and injectables

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

*** Each $1.00 paid PMPM = $818 in plan costs.**

Exhibit 8-G

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - Standard
Comparison of 2007 to 2006



			Difference	
	2006 *	2007 **	$	%
Facility Inpatient	$193.63	$129.91	-$63.72	-32.9%
Facility Outpatient	$144.45	$154.53	$10.08	7.0%
Physician	$174.92	$179.49	$4.57	2.6%
Drugs	$216.78	$93.15	-$123.63	-57.0%
Other Services	$51.31	$42.85	-$8.46	-16.5%
Totals	$781.09	$599.93	-$181.16	-23.2%

Note: Drug includes prescription and injectables

*** Each $1.00 paid PMPM = $1,273 in plan costs.**

**** Each $1.00 paid PMPM = $818 in plan costs.**

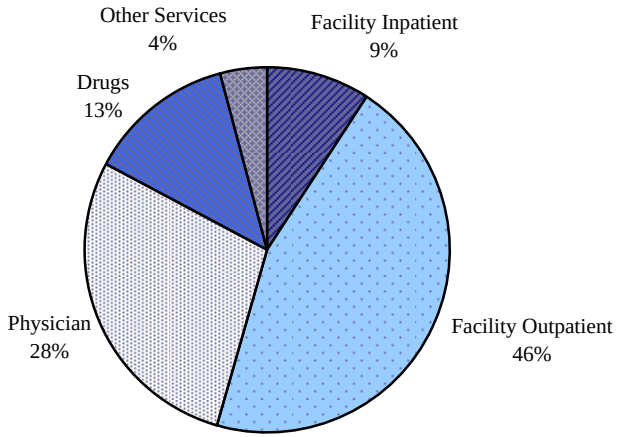
Exhibit 8-H

WISCONSIN PUBLIC EMPLOYERS

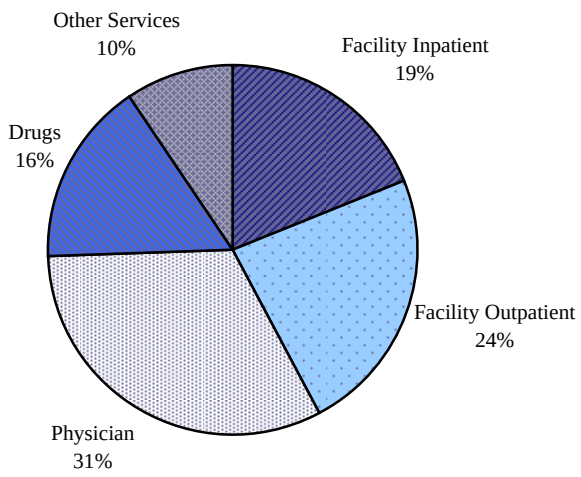
Total PMPM by Type of Service - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

Actual PMPM



Benchmark PMPM



			Difference	
	Actual	Benchmark	$	%
Facility Inpatient	**$34.48**	**$57.14**	**-$22.66**	**-39.7%**
Facility Outpatient	**$167.76**	**$71.72**	**$96.04**	**133.9%**
Physician	**$105.88**	**$97.53**	**$8.35**	**8.6%**
Drugs	**$48.26**	**$49.02**	**-$0.76**	**-1.6%**
Other Services	**$15.47**	**$29.13**	**-$13.66**	**-46.9%**
Totals	**$371.85**	**$304.54**	**$67.31**	**22.1%**

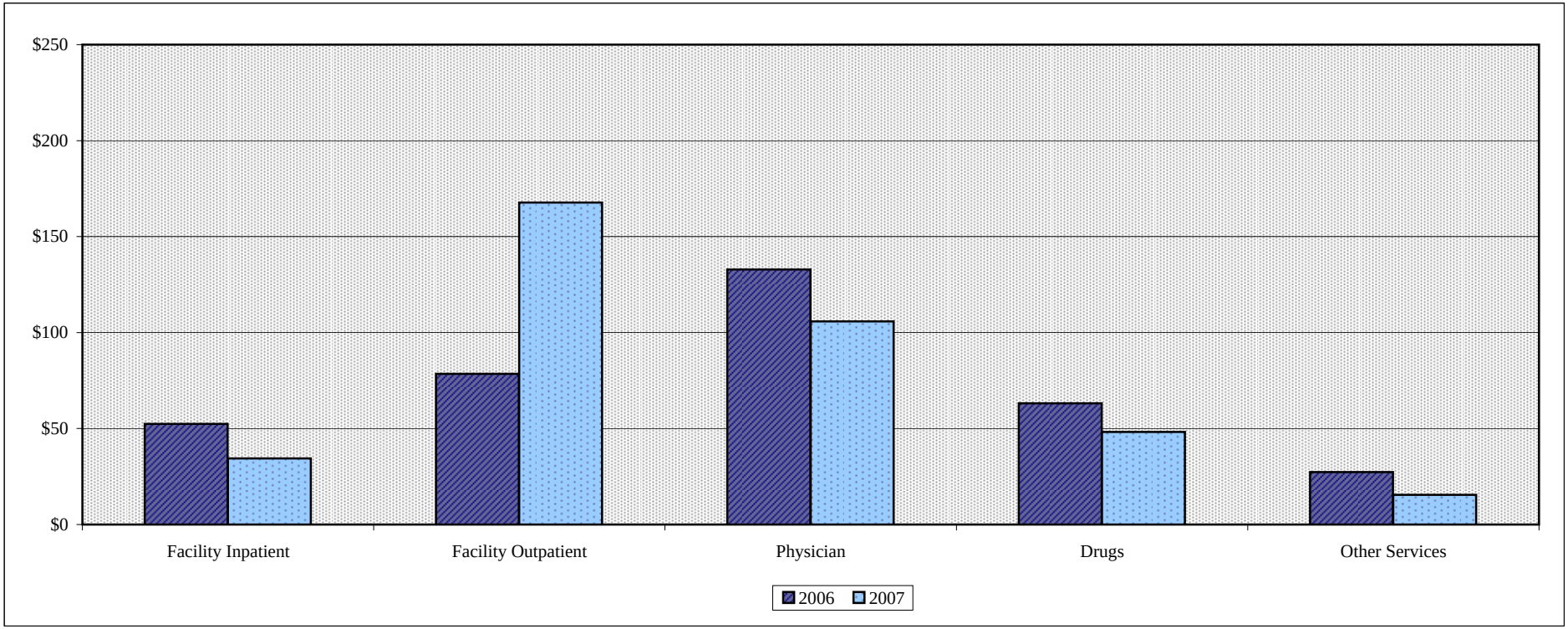
Note: Drug includes prescription and injectables

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

*** Each $1.00 paid PMPM = $522 in plan costs.**

Exhibit 8-I

WISCONSIN PUBLIC EMPLOYERS
Total PMPM by Type of Service - SMP
Comparison of 2007 to 2006



			Difference	
	2006 *	2007 **	$	%
Facility Inpatient	$52.38	$34.48	-$17.90	-34.2%
Facility Outpatient	$78.45	$167.76	$89.31	113.8%
Physician	$132.91	$105.88	-$27.03	-20.3%
Drugs	$63.22	$48.26	-$14.96	-23.7%
Other Services	$27.28	$15.47	-$11.81	-43.3%
Totals	$354.24	$371.85	$17.61	5.0%

Note: Drug includes prescription and injectables

*** Each $1.00 paid PMPM = $2,407 in plan costs.**

**** Each $1.00 paid PMPM = $522 in plan costs.**

Type of Service Detail

The Type of Service Detail report provides an overview of paid medical costs on a PMPM basis divided into 5 major service categories and further divided into 26 subcategories. The Actual PMPM costs are compared to the Benchmark PMPM to help determine where the plan is experiencing higher than normal claim costs. The comparison to the Benchmark is displayed as a PMPM difference and as a percentage difference. The Actual PMPM cost are for claims incurred January 2007 – December 2007 and paid through the end of March 2008.

Standard Plan

The Standard Plan in Exhibit 9-C was 3.9% below the benchmark in 2007. Due to the very small size of this group, the health conditions of a few members can have a significant impact on individual sub-categories. Therefore, meaningful conclusions cannot always be made. Since the percentage comparison can be deceiving, it is more important to look at the PMPM difference with $1.00 PMPM being equivalent to $818 in annual plan costs. Below are some areas that stand out relative to the benchmark and some analysis on what is driving the higher costs.

- Facility Inpatient – The majority of dollars here are for surgical/medical services. The lower than expected results in this category are directly correlated to the lack of high cost patients.

- Outpatient Facility – The surgical/medical sub-category is 88.2% above the norm. This overage is most like driven by the health conditions of this small population.

- Physician – The maternity sub-category is running 67.9% above the norm. Given the small population, a small number of pregnancies could skew this number. Surgery and Anesthesia sub-categories are also running well above the norm. Claim costs for these two services are highly correlated.

- Drug – The prescription drug costs are in line with the benchmark while injectible drugs are well below the benchmark.

- Other services – The other services category is $2.69 PMPM above the benchmark. The major contributor to the variance is the Psych/AODA sub-category which is $11.97 PMPM above the benchmark. In 2007, over 23% of the plan members utilized this benefit.

SMP Plan

The SMP Plan in Exhibit 9-D by comparison is 22.1% above the benchmark for 2007. Due to the very small size of this group, the health conditions of a few members can have a significant impact on individual sub-categories. Therefore, meaningful conclusions cannot always be made. For the plan $1.00 PMPM represented in the chart is equivalent to $522 in annual plan costs.

- Inpatient Facility - All of dollars here are for surgical/medical services. The lower than expected results in this category are directly correlated to the lack of high cost patients.

- Outpatient Facility – This category is 133.9% above the benchmark. This overage is most like driven by the health conditions of this small population.

- Physician – The Surgery and Anesthesia sub-categories are running well above the norm. Claim costs for these two services are highly correlated.

- Drug – The prescription drug PMPM cost is running 8.4% above the norm and the injectable drug costs are running 76.8% below norm. Overall the drug cost is lower than the total plan performance for 2007.

- Other Services – The Chiropractic sub-category is $4.51 PMPM above the norm which is a function of the region in which the SMP population resides. In the northern region, chiropractic care is more commonly used to treat back problems in comparison to other areas of the state.

Exhibit 9-C

WISCONSIN PUBLIC EMPLOYERS

Type of Service Detail - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE $	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	$129.46	$135.36	-$5.90	-4.4%
	PSYCH/AODA	$0.00	$1.53	-$1.53	-100.0%
	MATERNITY	$0.00	$1.07	-$1.07	-100.0%
	OTHER	$0.45	$1.52	-$1.07	-70.4%
	Subtotal	**$129.91**	**$139.48**	**-$9.57**	**-6.9%**
FACILITY OUTPATIENT	SURGICAL/MEDICAL	$50.89	$27.04	$23.85	88.2%
	RADIOLOGY	$36.68	$41.51	-$4.83	-11.6%
	PATHOLOGY	$14.65	$16.53	-$1.88	-11.4%
	EMERGENCY ROOM	$3.92	$4.06	-$0.14	-3.4%
	PSYCH/AODA	$0.00	$0.92	-$0.92	-100.0%
	OTHER	$48.39	$54.91	-$6.52	-11.9%
	Subtotal	**$154.53**	**$144.97**	**$9.56**	**6.6%**
PHYSICIAN	OFFICE VISIT	$15.71	$24.25	-$8.54	-35.2%
	RADIOLOGY	$27.13	$37.05	-$9.92	-26.8%
	PATHOLOGY	$21.81	$22.94	-$1.13	-4.9%
	SURGERY	$75.51	$61.42	$14.09	22.9%
	ANESTHESIA	$15.40	$12.07	$3.33	27.6%
	MATERNITY	$0.89	$0.53	$0.36	67.9%
	OTHER	$23.04	$35.29	-$12.25	-34.7%
	Subtotal	**$179.49**	**$193.55**	**-$14.06**	**-7.3%**
DRUGS	PRESCRIPTIONS	$92.85	$93.49	-$0.64	-0.7%
	INJECTABLES	$0.30	$12.38	-$12.08	-97.6%
	Subtotal	**$93.15**	**$105.87**	**-$12.72**	**-12.0%**
OTHER SERVICES	PSYCH/AODA	$17.10	$5.13	$11.97	233.3%
	CHIROPRACTIC	$6.50	$3.83	$2.67	69.7%
	THERAPIES	$3.77	$4.41	-$0.64	-14.5%
	AMBULANCE	$0.00	$2.21	-$2.21	-100.0%
	WELL BABY EXAM	$0.00	$0.04	-$0.04	-100.0%
	DURABLE MEDICAL EQUIPMENT	$1.98	$6.80	-$4.82	-70.9%
	OTHER	$13.50	$17.74	-$4.24	-23.9%
	Subtotal	**$42.85**	**$40.16**	**$2.69**	**6.7%**
Grand Total		**$599.93**	**$624.03**	**-$24.10**	**-3.9%**

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

*** Each $1.00 paid PMPM = $818 in plan costs.**

Exhibit 9-D

WISCONSIN PUBLIC EMPLOYERS

Type of Service Detail - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

TYPE OF SERVICE	DETAIL	ACTUAL PMPM	BENCHMARK PMPM	DIFFERENCE $	DIFFERENCE %
FACILITY INPATIENT	SURGICAL/MEDICAL	$34.48	$50.54	-$16.06	-31.8%
	PSYCH/AODA	$0.00	$1.80	-$1.80	-100.0%
	MATERNITY	$0.00	$4.27	-$4.27	-100.0%
	OTHER	$0.00	$0.53	-$0.53	-100.0%
	Subtotal	**$34.48**	**$57.14**	**-$22.66**	**-39.7%**
FACILITY OUTPATIENT	SURGICAL/MEDICAL	$32.37	$13.96	$18.41	131.9%
	RADIOLOGY	$55.80	$19.19	$36.61	190.8%
	PATHOLOGY	$26.85	$7.65	$19.20	251.0%
	EMERGENCY ROOM	$11.91	$3.11	$8.80	283.0%
	PSYCH/AODA	$0.70	$1.16	-$0.46	-39.7%
	OTHER	$40.13	$26.65	$13.48	50.6%
	Subtotal	**$167.76**	**$71.72**	**$96.04**	**133.9%**
PHYSICIAN	OFFICE VISIT	$14.17	$13.49	$0.68	5.0%
	RADIOLOGY	$12.37	$17.45	-$5.08	-29.1%
	PATHOLOGY	$3.61	$12.13	-$8.52	-70.2%
	SURGERY	$50.29	$29.46	$20.83	70.7%
	ANESTHESIA	$10.75	$5.99	$4.76	79.5%
	MATERNITY	$0.00	$2.23	-$2.23	-100.0%
	OTHER	$14.69	$16.78	-$2.09	-12.5%
	Subtotal	**$105.88**	**$97.53**	**$8.35**	**8.6%**
DRUGS	PRESCRIPTIONS	$46.93	$43.29	$3.64	8.4%
	INJECTABLES	$1.33	$5.73	-$4.40	-76.8%
	Subtotal	**$48.26**	**$49.02**	**-$0.76**	**-1.6%**
OTHER SERVICES	PSYCH/AODA	$0.00	$6.52	-$6.52	-100.0%
	CHIROPRACTIC	$7.26	$2.75	$4.51	164.0%
	THERAPIES	$0.00	$2.75	-$2.75	-100.0%
	AMBULANCE	$3.41	$1.16	$2.25	194.0%
	WELL BABY EXAM	$0.00	$0.00	$0.00	0.0%
	DURABLE MEDICAL EQUIPMENT	$0.00	$3.44	-$3.44	-100.0%
	OTHER	$4.80	$12.51	-$7.71	-61.6%
	Subtotal	**$15.47**	**$29.13**	**-$13.66**	**-46.9%**
Grand Total		**$371.85**	**$304.54**	**$67.31**	**22.1%**

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

*** Each $1.00 paid PMPM = $522 in plan costs.**

Inpatient Utilization, Days/1000 and Average Length of Stay

The Inpatient Utilization report compares annual inpatient days per 1,000, admits per 1,000, average length of stay, cost per day, cost per admit, and inpatient PMPM cost to the benchmark for the 5 major inpatient service categories. Days/1000 is the annual average number of hospital days utilized by a population of 1,000 members which is calculated by taking (Total Days/Member Months)*12000. The Admits/1000 is the annual number of admits that occur within a typical population of 1,000 members which is calculated by taking (Total Admits/Member Months)*12000. The Days/1000 and Admits/1000 are calculations that allow a comparison of one population to another regardless of group size. Average Length of Stay (ALOS) shows the average length of hospitalization experienced for the entire group (Total Days/Total Admits). Cost per Day is an average of the cost per hospital day (Total Cost/Total Days). The cost per admit is an average of the cost per hospital admission (Total Cost/Total Admits). Lastly the inpatient PMPM is the per member per month cost incurred by the plan. Beyond the numerical comparison, a percentage has been included as observed in the pie charts, including a comparison to the benchmark.

Standard Plan

The totals for the Standard Plan in Exhibit 10-D are below the benchmark in most inpatient statistics. Due to the small size of this group the inpatient claim results are highly volatile from year to year and accurate predictions of future trends cannot be made. This year the group did not have any members with annual claims over $100,000 and thus experienced lower than expected inpatient costs. Of the costs that were incurred 88.5% were in the surgical sub-category.

SMP

No SMP report due to small size of block and lack of credibility.

Exhibit 10-D

WISCONSIN PUBLIC EMPLOYERS

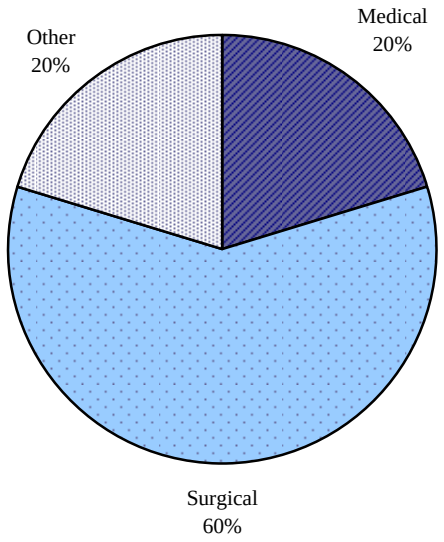
Inpatient Utilization - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

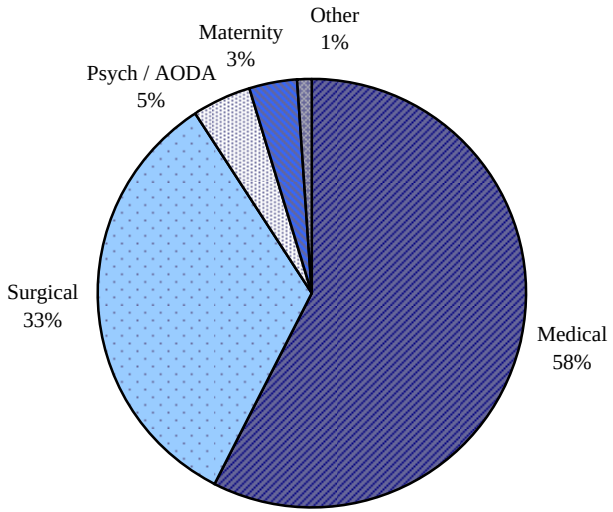
ACTUAL	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	29	176	0	0	132	337
Admits/1000	15	44	0	0	15	74
ALOS	2.00	4.00	0.00	0.00	9.00	4.60
Cost/Day	$5,940	$7,835	$0	$0	$41	$4,620
Cost/Admit	$11,880	$31,338	$0	$0	$372	$21,254
PMPM	$14.52	$114.93	$0.00	$0.00	$0.45	$129.90
% of Paid	11.18%	88.48%	0.00%	0.00%	0.35%	100.00%

BENCHMARK	Medical	Surgical	Psych / AODA	Maternity	Other	Total
Days/1000	242	139	18	7	69	475
Admits/1000	50	29	4	3	1	87
ALOS	4.84	4.79	4.50	2.33	69.00	5.46
Cost/Day	$3,140	$6,667	$1,024	$1,616	$286	$3,576
Cost/Admit	$15,620	$33,701	$5,433	$2,843	$17,060	$23,241
PMPM	$60.95	$74.41	$1.53	$1.07	$1.52	$139.48
% of Paid	43.70%	53.35%	1.10%	0.77%	1.09%	100.00%

% OF ADMITS FOR ACTUAL



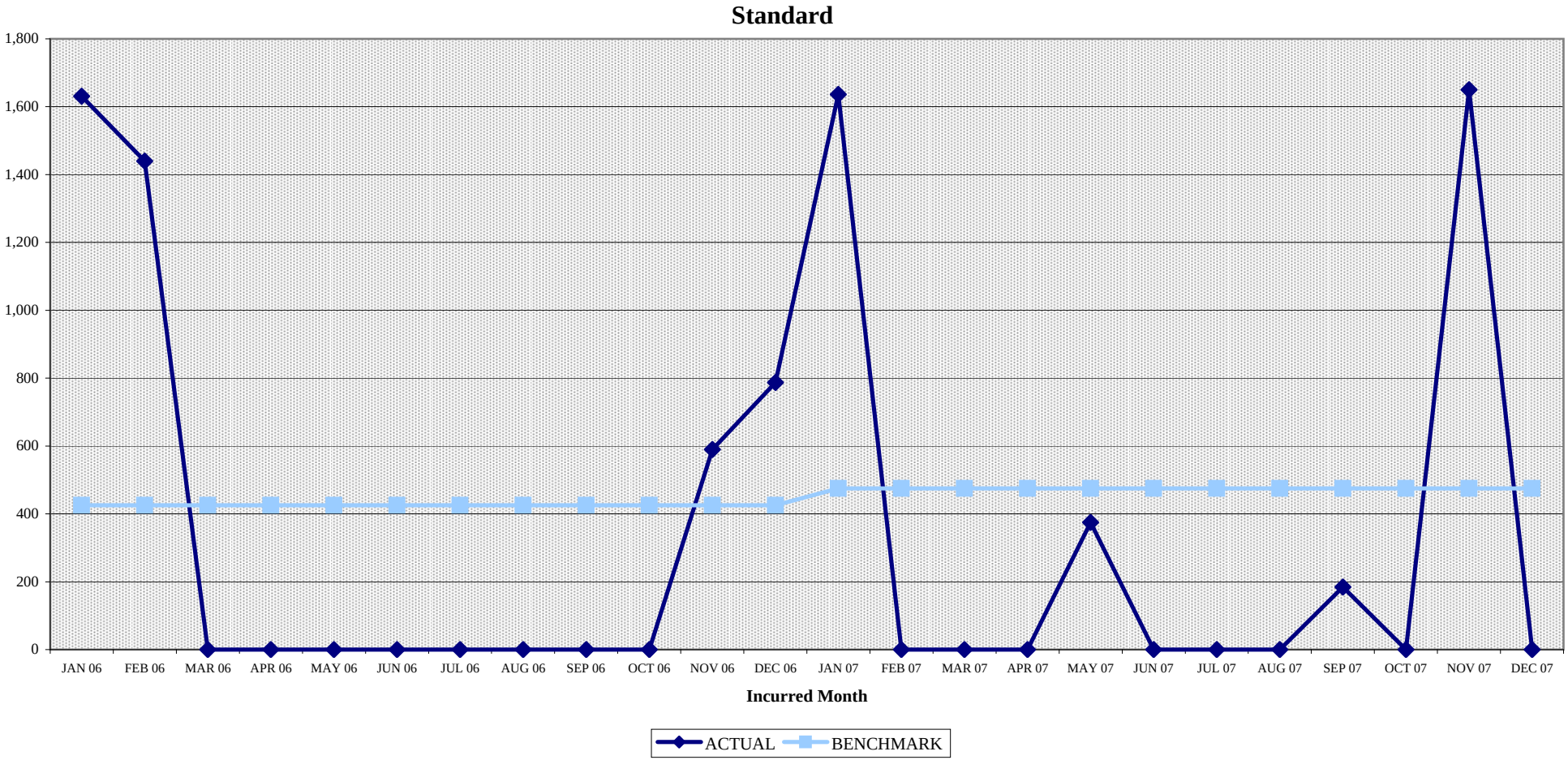
% OF ADMITS FOR BENCHMARK



Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Exhibit 10-E

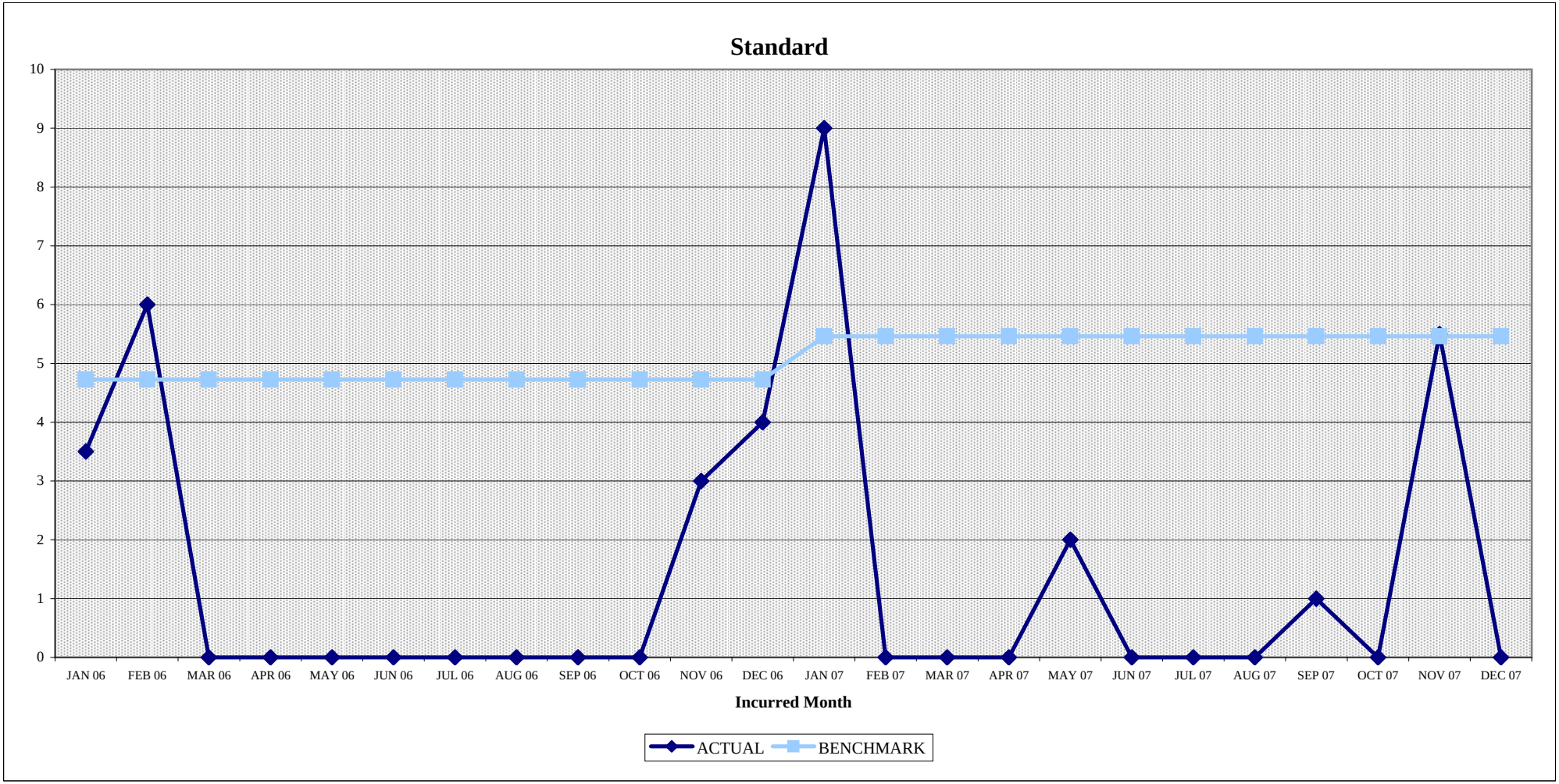
WISCONSIN PUBLIC EMPLOYERS
Monthly Inpatient Days/1000
Paid Through March 2008



Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Exhibit 10-F

WISCONSIN PUBLIC EMPLOYERS
Monthly Inpatient Average Length of Stay
Paid Through March 2008



Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Claim Costs by Major Diagnostic Categories (MDC)

The Claim Costs by Major Diagnostic Categories report divides medical claim costs into 25 mutually exclusive diagnostic categories. The category descriptions have been modified to incorporate simpler, more easily understood terms when compared to last years report. The diagnoses in each MDC correspond to a single organ system and, in general, are associated with a particular medical specialty. The actual PMPM cost by major diagnostic category is compared to the WPS benchmark PMPM. The Actual PMPM costs show calendar year results, comparing 2006 to 2007, each with three months run-out.

Prior exhibits have shown the **Standard Plan** is slightly below the benchmark overall. Exhibits 11-C show this deviation by MDC. Due to the small size of this group, the splitting of claims into small categories is highly volatile which is can be seen in large positive and negative comparisons. The individual health conditions of each member can affect a single sub-category. Therefore, this graph is for informational purposes only and we cannot make any recommendations based on the data presented. For the Standard Plan $1.00 PMPM in claim cost represented in the charts is equivalent to $818 in annual plan costs.

The **SMP Plan,** shown in Exhibits 11-D is experiencing higher than expected PMPM Cost overall. Once again the small size of this segment is creating large volatility in the results of individual categories which is seen in the large positive and negative comparisons. Therefore, this graph is for informational purposes only and we cannot make any recommendations based on the data presented. For the SMP plan $1.00 PMPM in claim cost represented in the charts is equivalent to $522 in annual plan costs.

Exhibit 11-C

WISCONSIN PUBLIC EMPLOYERS

Claim Costs by Major Diagnostic Categories - Standard

Comparison of 2007 to 2006

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2006 ACTUAL PMPM *	2007 ACTUAL PMPM **	BENCHMARK PMPM **	DIFFERENCE 2007 to 2006	DIFFERENCE 2007 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	$22.63	$20.04	$31.05	-11.4%	-35.5%
2	Eye D/D	$6.28	$11.30	$16.31	79.9%	-30.7%
3	Ear, Nose, Mouth and Throat D/D	$11.73	$5.43	$17.10	-53.7%	-68.2%
4	Respiratory System D/D	$44.74	$1.76	$22.58	-96.1%	-92.2%
5	Circulatory System D/D	$104.48	$41.69	$81.51	-60.1%	-48.9%
6	Digestive System D/D	$43.28	$48.23	$50.05	11.4%	-3.6%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	$11.94	$4.16	$12.84	-65.2%	-67.6%
8	Muscles, Bones, and Connective Tissue D/D	$160.16	$222.59	$107.17	39.0%	107.7%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	$161.97	$19.82	$29.22	-87.8%	-32.2%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	$44.21	$11.45	$17.13	-74.1%	-33.2%
11	Kidney and Urinary Tract D/D	$7.89	$2.99	$22.44	-62.1%	-86.7%
12	Male Reproductive System D/D	$2.52	$3.21	$7.92	27.4%	-59.5%
13	Female Reproductive System D/D	$5.27	$23.27	$14.01	341.6%	66.1%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	$0.00	$9.55	$1.95	0.0%	390.2%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	$0.00	$0.00	$1.41	0.0%	-100.0%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	$2.81	$5.19	$4.59	84.7%	13.1%
17	Bone Marrow D/D and Poorly Differentiated Cancers	$3.05	$0.35	$14.62	-88.5%	-97.6%
18	Infectious and Parasitic Diseases	$0.78	$0.20	$5.43	-74.4%	-96.3%
19	Behavioral Health Diagnoses	$9.57	$15.45	$8.95	61.4%	72.6%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	$0.07	$2.07	$1.34	2857.1%	54.3%
21	Injuries, Poisoning and Toxic Effects of Drugs	$0.55	$0.03	$5.12	-94.5%	-99.4%
22	Burns	$0.09	$0.00	$0.10	-100.0%	-100.0%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	$29.51	$57.96	$53.77	96.4%	7.8%
24	Multiple Significant Trauma	$0.00	$0.00	$1.78	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	$0.00	$0.00	$0.05	0.0%	-100.0%
0	Ungroupable	$0.04	$0.32	$2.10	700.0%	-84.7%
	Total	**$673.57**	**$507.06**	**$530.54**	**-24.7%**	**-4.4%**

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Note: The MDC descriptions used in last year's report have been modified in an attempt to help readers understand the type of data that is contained in each category

*** Each $1.00 paid PMPM = $1,273 in plan costs.**

**** Each $1.00 paid PMPM = $818 in plan costs.**

Exhibit 11-D

WISCONSIN PUBLIC EMPLOYERS
Claim Costs by Major Diagnostic Categories - SMP
Comparison of 2007 to 2006

MDC CODE	MAJOR DIAGNOSTIC CATEGORY DESCRIPTION	2006 ACTUAL PMPM *	2007 ACTUAL PMPM **	BENCHMARK PMPM **	DIFFERENCE 2007 to 2006	DIFFERENCE 2007 to BENCHMARK
1	Nervous System Diseases and Disorders (D/D)	$6.84	$1.89	$14.09	-72.4%	-86.6%
2	Eye D/D	$4.25	$1.57	$4.80	-63.1%	-67.3%
3	Ear, Nose, Mouth and Throat D/D	$20.73	$7.60	$16.34	-63.3%	-53.5%
4	Respiratory System D/D	$10.94	$20.09	$9.28	83.6%	116.5%
5	Circulatory System D/D	$52.31	$41.65	$25.91	-20.4%	60.7%
6	Digestive System D/D	$26.26	$43.58	$26.70	66.0%	63.3%
7	Liver, Gallbladder, Biliary Ducts and Pancreas D/D	$0.00	$12.37	$5.94	0.0%	108.4%
8	Muscles, Bones, and Connective Tissue D/D	$51.82	$70.16	$44.70	35.4%	57.0%
9	Skin, Subcutaneous Tissue (fat and connective) and Breast D/D	$9.78	$6.71	$13.07	-31.4%	-48.7%
10	Endocrine, Nutritional and Metabolic D/D (included diagnoses related to obesity, diabetes and hormones)	$13.84	$16.47	$7.79	19.0%	111.3%
11	Kidney and Urinary Tract D/D	$12.13	$30.59	$8.01	152.2%	282.0%
12	Male Reproductive System D/D	$0.57	$0.42	$2.16	-26.3%	-80.6%
13	Female Reproductive System D/D	$31.21	$48.73	$9.39	56.1%	419.1%
14	Pregnancy, Childbirth, and After Delivery Diagnoses	$6.48	$0.00	$11.55	-100.0%	-100.0%
15	Newborns, and Newborns with Conditions Originating Shortly Before or After Birth	$0.42	$0.00	$7.06	-100.0%	-100.0%
16	Blood and Blood Forming Organ D/D (including spleen) and Immune System Disorders	$0.42	$8.12	$2.19	1833.3%	270.7%
17	Bone Marrow D/D and Poorly Differentiated Cancers	$1.52	$0.00	$6.02	-100.0%	-100.0%
18	Infectious and Parasitic Diseases	$0.71	$1.79	$2.64	152.1%	-32.2%
19	Behavioral Health Diagnoses	$12.87	$0.96	$9.06	-92.5%	-89.4%
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders	$0.00	$0.00	$1.38	0.0%	-100.0%
21	Injuries, Poisoning and Toxic Effects of Drugs	$1.12	$0.91	$2.76	-18.8%	-67.0%
22	Burns	$0.00	$0.00	$0.37	0.0%	-100.0%
23	Other Miscellaneous Services Including Health Screenings, Medical Exams and Rehabilitation	$26.10	$9.83	$27.87	-62.3%	-64.7%
24	Multiple Significant Trauma	$0.00	$0.00	$0.90	0.0%	-100.0%
25	Human Immunodeficiency Virus Infections	$0.00	$0.00	$0.04	0.0%	-100.0%
0	Ungroupable	$1.01	$1.50	$1.23	48.5%	21.7%
	Total	**$291.33**	**$324.94**	**$261.25**	**11.5%**	**24.4%**

Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Note: The MDC descriptions used in last year's report have been modified in an attempt to help readers understand the type of data that is contained in each category

*** Each $1.00 paid PMPM = $2,407 in plan costs.**

**** Each $1.00 paid PMPM = $522 in plan costs.**

Top 20 Providers

The Top 20 Provider reports display the top 20 Facility and Professional Providers sorted by total paid charges. Within the facility report, charges have also been broken out by inpatient and outpatient paid charges for additional analysis. The Paid % shows the percentage of the group's total facility or professional charges from a specific provider.

Facility

The report for the **Standard Plan** in Exhibit 12-E shows that the top 20 facilities provide 91.6% of the total facility charges for the plan. The largest percent of claims came from St Francis Hospital in Milwaukee. The second largest percent of claims came from Lakeview Memorial Hospital in Stillwater, Minnesota. You will note that most of the hospitals in the top 20 treated only one patient. Since the Standard Plan is available nationwide, we see providers from various regions and states.

The report for the **SMP Plan** in Exhibit 12-F shows that the top 7 facilities provide 100% of the total facility charges for the plan. The vast majority of claims came from Dickinson County Memorial Hospital in Iron Mountain, Michigan. This hospital also saw the most patients with 26. Due to the HMO type coverage and limited plan area of the SMP plan we would expect to see a majority of services received at a finite number of hospitals within the SMP region.

Professional

The **Standard Plan** shown in Exhibit 12-G received 52.7% of professional charges from the top 20 providers. The top professional provider is Kagan Jugan Associates in Fort Myers, Florida. Once again most providers in the top 20 only treated one patient. The top Wisconsin provider by paid claims and number of patients treated was the UW Medical Foundation in Madison.

The **SMP Plan** in Exhibit 12-H received 88.6% of the paid claims from the top 20 professional providers. Dickinson Memorial Hospital was again the top provider in both paid dollars and patients treated. You will note that most of the services were provided in Iron Mountain, Michigan.

Exhibit 12-E

WISCONSIN PUBLIC EMPLOYERS

Top 20 Facility Providers - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	ST FRANCIS HOSPITAL	MILWAUKEE	WI	1	$41,570	$1,001	$42,571	18.3%
2	LAKEVIEW MEMORIAL HOSPITAL	STILLWATER	MN	1	$25,467	$0	$25,467	10.9%
3	SAINT JOSEPH HEALTH CTR	KANSAS CITY	MO	1	$11,143	$4,731	$15,874	6.8%
4	WHEATON FRANCISCAN HEALTHCARE	MILWAUKEE	WI	1	$15,835	$0	$15,835	6.8%
5	MERITER HOSPITAL INC	MADISON	WI	3	$11,880	$3,488	$15,368	6.6%
6	PHYSICIANS SURG CTR	FORT MYERS	FL	1	$0	$12,794	$12,794	5.5%
7	AURORA MEDICAL CTR HARTFORD	HARTFORD	WI	1	$0	$12,042	$12,042	5.2%
8	COLUMBIA ST MARYS HOSPITAL COL	MILWAUKEE	WI	1	$0	$9,759	$9,759	4.2%
9	FOND DU LAC SURGERY CTR	FOND DU LAC	WI	1	$0	$9,707	$9,707	4.2%
10	CUMBERLAND MEMORIAL HOSPITAL	CUMBERLAND	WI	3	$0	$8,471	$8,471	3.6%
11	AURORA ST LUKES MEDICAL CTR	MILWAUKEE	WI	4	$0	$7,463	$7,463	3.2%
12	MURRAY-CALLOWY CTY HSP	MURRAY	KY	1	$0	$5,889	$5,889	2.5%
13	UNIVERSITY WI HSP CL AUTHORITY	MADISON	WI	4	$0	$5,342	$5,342	2.3%
14	UPLAND HILLS HEALTH	DODGEVILLE	WI	1	$0	$5,314	$5,314	2.3%
15	OAKLEAF SURGICAL HOSPITAL	EAU CLAIRE	WI	1	$0	$4,184	$4,184	1.8%
16	ST FRANCIS HOSP INC	COLUMBUS	GA	1	$0	$4,157	$4,157	1.8%
17	SARASOTA MEM HOSP	SARASOTA	FL	3	$0	$4,027	$4,027	1.7%
18	ASSOCIATED EYE CARE AMBUL	STILLWATER	MN	1	$0	$3,147	$3,147	1.4%
19	LAKEVIEW MED CTR	RICE LAKE	WI	1	$0	$2,996	$2,996	1.3%
20	LEESBURG REG MED CTR	LEESBURG	FL	1	$0	$2,641	$2,641	1.1%
	Top 20 Total			**32**	**$105,895**	**$107,153**	**$213,048**	**91.6%**
	All Other Facility Charges			**29**	**$372**	**$19,260**	**$19,632**	**8.4%**
	Total Facility Charges			**61**	**$106,267**	**$126,413**	**$232,680**	**100.0%**

Exhibit 12-F

WISCONSIN PUBLIC EMPLOYERS

Top 20 Facility Providers - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

	Facility Provider	City	State	# of Unique Patients	Inpatient Paid Claims	Outpatient Paid Claims	Total Paid Claims	Paid %
1	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	26	$18,001	$68,798	$86,799	82.2%
2	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	1	$0	$7,365	$7,365	7.0%
3	BELLIN MEMORIAL HOSP	GREEN BAY	WI	1	$0	$6,010	$6,010	5.7%
4	FRANCISCAN SKEMP MEDICAL CENTE	LA CROSSE	WI	1	$0	$2,293	$2,293	2.2%
5	NIAGARA HEALTH CTR	NIAGARA	WI	1	$0	$1,190	$1,190	1.1%
6	MARQUETTE MEDICAL CL	KINGSFORD	MI	3	$0	$1,004	$1,004	1.0%
7	ST VINCENT HOSPITAL	GREEN BAY	WI	2	$0	$909	$909	0.9%
	Top 7 Total			**35**	**$18,001**	**$87,569**	**$105,570**	**100.0%**
	All Other Facility Charges			**0**	**$0**	**$0**	**$0**	**0.0%**
	Total Facility Charges			**35**	**$18,001**	**$87,569**	**$105,570**	**100.0%**

Exhibit 12-G

WISCONSIN PUBLIC EMPLOYERS

Top 20 Professional Providers - Standard

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	KAGAN JUGAN ASSOCIATES PA	FORT MYERS	FL	1	$10,955	6.0%
2	UW MEDICAL FOUNDATION	MADISON	WI	7	$10,548	5.8%
3	SPORTS MEDICINE & ORTHOPEDIC	MILWAUKEE	WI	1	$9,958	5.5%
4	DEAN MEDICAL CTR	MADISON	WI	3	$7,642	4.2%
5	ST CROIX ORTHOPAEDICS PA	STILLWATER	MN	1	$7,309	4.0%
6	LAKEFRONT WELLNESS CENTER SC	PEWAUKEE	WI	4	$6,269	3.4%
7	FLORIDA HEART & VASCULAR CTR	LEESBURG	FL	1	$5,312	2.9%
8	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	4	$4,729	2.6%
9	CLEARVIEW MEDICAL IMAGING LLC	MILWAUKEE	WI	1	$4,665	2.6%
10	INTERVENTIONAL PAIN SPECIALIST	RICE LAKE	WI	1	$3,967	2.2%
11	ASSOCIATED EYE CARE	STILLWATER	MN	1	$3,443	1.9%
12	BARRY K GIMBEL MD SC	MILWAUKEE	WI	1	$2,862	1.6%
13	FAMILY FOOT CLINIC SC	FOND DU LAC	WI	1	$2,647	1.5%
14	MIDWEST ANESTHESIA CONSULTANTS	MILWAUKEE	WI	1	$2,419	1.3%
15	MEDICAL COLLEGE OF WISCONSIN	MILWAUKEE	WI	3	$2,299	1.3%
16	CARONDELET SPECIALTY CARE NETW	KANSAS CITY	MO	1	$2,264	1.2%
17	PLASTIC SURGERY CLINIC	EAU CLAIRE	WI	1	$2,246	1.2%
18	JULIE CHICKS MD SC	CEDARBURG	WI	1	$2,187	1.2%
19	CUMBERLAND CLINIC SC	CUMBERLAND	WI	3	$2,176	1.2%
20	M M PHYSICAL THERAPY LLC	S MILWAUKEE	WI	1	$2,127	1.2%
	Top 20 Total			**38**	**$96,024**	**52.7%**
	All Other Professional Charges			**231**	**$86,089**	**47.3%**
	Total Professional Charges			**269**	**$182,113**	**100.0%**

Exhibit 12-H

WISCONSIN PUBLIC EMPLOYERS

Top 20 Professional Providers - SMP

Incurred January 2007 - December 2007 Paid Through March 2008

	Professional Provider	City	State	# of Unique Patients	Total Paid Claims	Paid %
1	DICKINSON COUNTY MEMORIAL HOSP	IRON MOUNTAIN	MI	16	$7,926	12.4%
2	BAYCARE CLINIC LLP	MARINETTE	WI	1	$7,634	11.9%
3	BENISHEK CECCONI AND TERRIAN	IRON MOUNTAIN	MI	4	$7,510	11.7%
4	JOHN M COOK MD PC	IRON MOUNTAIN	MI	4	$4,593	7.2%
5	UROLOGY ASSOC OF GREEN BAY SC	GREEN BAY	WI	3	$4,560	7.1%
6	RADIOLOGY ASSOC IRON MTN	IRON MOUNTAIN	MI	16	$3,888	6.1%
7	NORTHERN MICHIGAN ANESTHESIA	IRON MOUNTAIN	MI	3	$3,835	6.0%
8	MARQUETTE MEDICAL CL	KINGSFORD	MI	7	$2,136	3.3%
9	BEGRES CHIROPRACTIC	IRON MOUNTAIN	MI	9	$2,126	3.3%
10	WISCONSIN MICHIGAN PHYSICIANS	NIAGARA	WI	1	$1,872	2.9%
11	BEACON AMBULANCE SVC	HURLEY	WI	1	$1,778	2.8%
12	NIAGARA CHIROPRACTIC	NIAGARA	WI	3	$1,458	2.3%
13	JAMES A BATTI MD	IRON MOUNTAIN	MI	10	$1,210	1.9%
14	AURORA MEDICAL GROUP OSHKOSH	OSHKOSH	WI	1	$1,137	1.8%
15	NORTHWOODS IMAGING ASSOC	IRON MOUNTAIN	MI	2	$1,099	1.7%
16	STEVEN HUNT	IRON MOUNTAIN	MI	1	$970	1.5%
17	HOSPITAL DIAGNOSTIC SVC	GREEN BAY	WI	1	$922	1.4%
18	JOHN H BARSCH MD	IRON MOUNTAIN	MI	1	$713	1.1%
19	MEDCO WACHOVIA	COLUMBUS	OH	1	$696	1.1%
20	MI-WI FAMILY PRACTICE ASSOC PC	IRON MOUNTAIN	MI	2	$668	1.0%
	Top 20 Total			**87**	**$56,731**	**88.6%**
	All Other Professional Charges			**29**	**$7,310**	**11.4%**
	Total Professional Charges			**116**	**$64,041**	**100.0%**

High Cost Patients

There are no high cost claimants, defined as members who have more than $100,000 in claims in the most recent 12 month period, on the WPE plan.

Medical and Drug Cost Sharing

The Medical and Drug Cost Sharing graphs in Exhibit 15-B show the percent of eligible medical and drug claim costs paid by the member. This percentage is compared to the WPS Benchmark.

The **Standard Plan** members pay about 6.0% of their own medical claims as compared to the benchmark of 6.7%. The prescription drug cost share is above our normative benchmark with the Standard Plan around 21.8% and the benchmark at 19.0%.

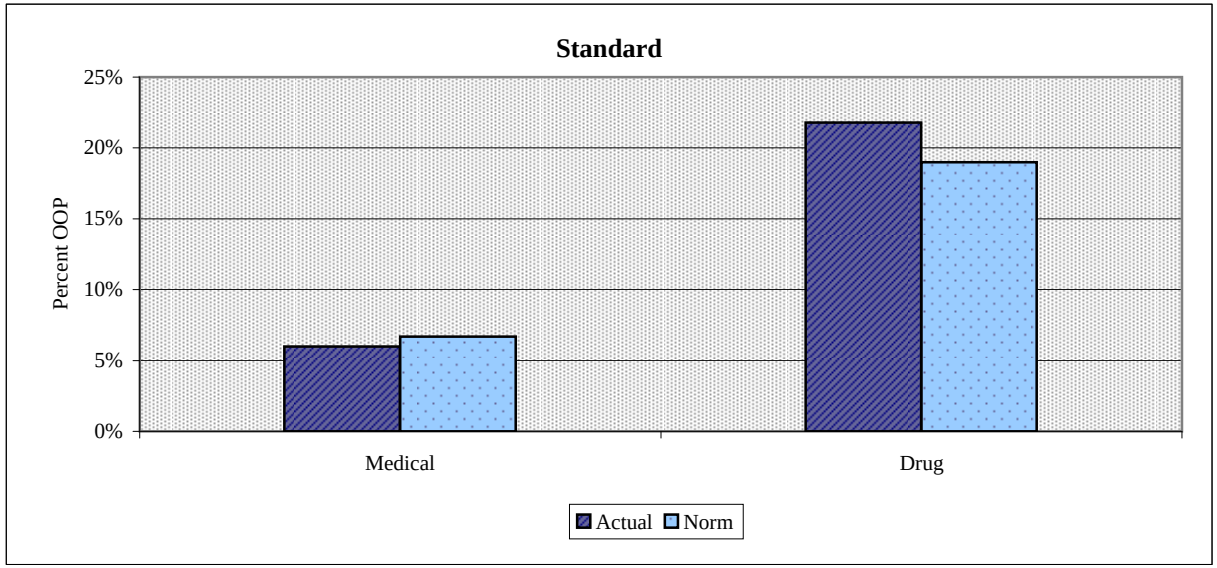
The **SMP Plan** members by comparison pay a smaller amount towards their own medical claims (in the form of cost sharing). Unlike the members of most large groups who pay an average of about 9.3% of their medical claims, SMP Plan members pay 1.0%. The SMP cost share for prescription drugs is just below the benchmark of 19.5%. Even though the Standard and SMP plans have the same prescription drug benefit, they have slightly different drug utilization profiles, the result of each plan's unique blend of treated conditions.

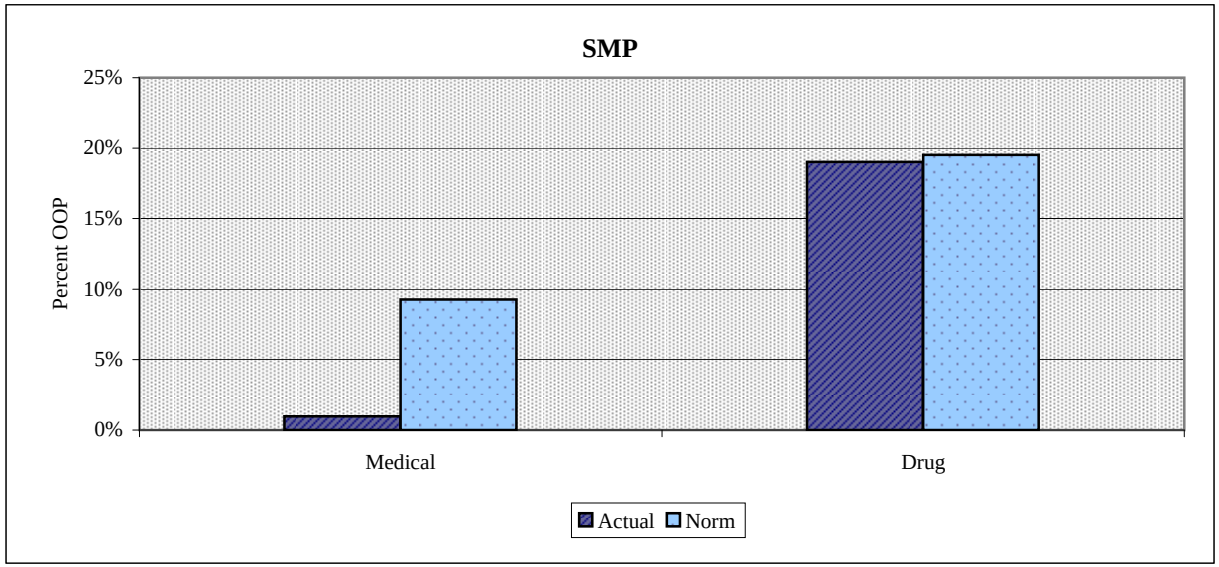
Exhibit 15-B

WISCONSIN PUBLIC EMPLOYERS

Medical and Drug Cost Sharing

Incurred January 2007 - December 2007 Paid Through March 2008





Note: Benchmark data has been age/sex adjusted to correspond to the population included in this exhibit

Medical and Drug Out of Pocket by Member

The Medical and Drug Out of Pocket by Member bar graph shown in Exhibit 16-B divides members with out of pocket cost sharing into categories based on the annual amount of out of pocket costs they paid in 2007. The annual out of pocket for each member includes medical and prescription drug costs.

The **Standard Plan** has a large disparity between the members as far as out of pocket costs. The distribution of out of pocket costs are fairly evenly distributed across the different categories, however there appears to be a bias towards the higher out of pocket costs. There are just over 16 members who pay over $1000 out of pocket annually. Also, there are over 15 members in the $500 to $999 range but it is important to note the range for this category is larger than the previous categories.

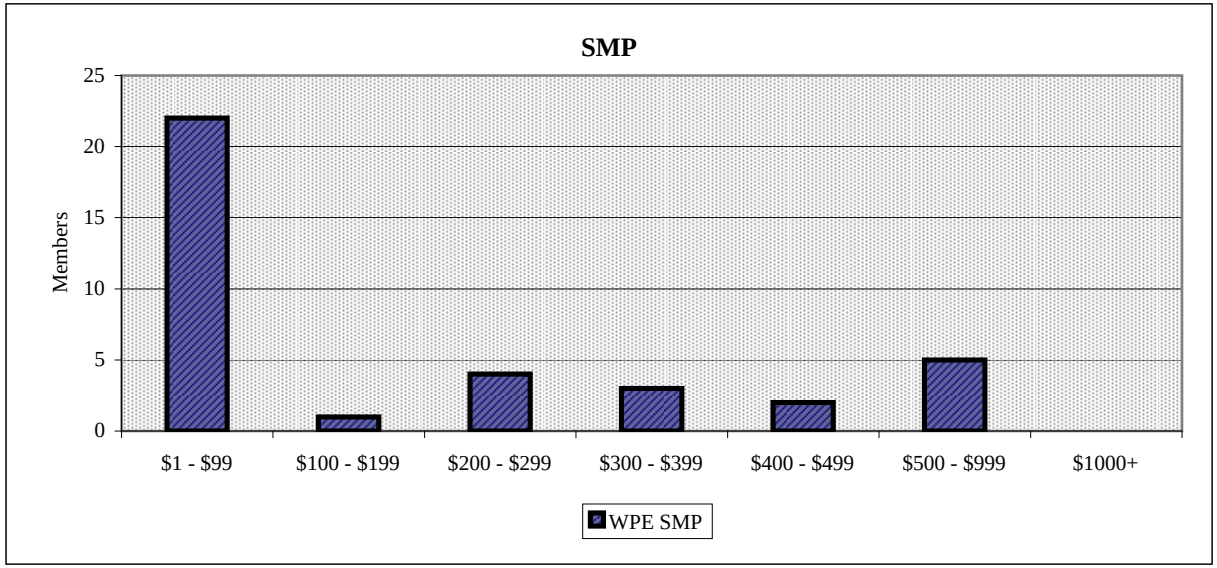
The **SMP Plan** by comparison has a large number of members paying between $1and $99 in cost sharing. Most of the cost sharing comes from prescription drug copays.

Exhibit 16-B

WISCONSIN PUBLIC EMPLOYERS

Medical and Drug Out of Pocket by Member

Incurred January 2007 - December 2007 Paid Through March 2008



Medical Claim Savings Analysis

The Medical Claim Saving Analysis in Exhibit 17-C takes the charges submitted on behalf of the ETF members and details the savings that take place before the final payments are made to the providers. The submitted charges represent medical claims only. The charges are split between the Standard, SMP and Medicare Carve-out plans for claims incurred January 2007 through December 2007 and paid through the end of March 2008. Exhibit 17-D provides a summary of the savings by plan along with a pie chart that provides the percentage of savings in each category combining all plans.

For the **Standard Plan**, WPS paid 76.2% of submitted charges on behalf of the plan. Of the 23.8% savings, 10.3% came from pricing cutbacks from the network providers. Another 3.7% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. The Standard Plan also had 4.9% of charges paid by the members with deductibles, coinsurance and copays. The savings due to third party liability is small at this time but these types of recoveries can be long term and may take several years to be completed.

For the **SMP Plan**, WPS paid 73.1% of submitted charges on behalf of the plan. Of the 26.9% savings, 9.8% was received from pricing cutbacks from network providers. Another 7.2% was saved on claims rejected for duplicate submission, non-eligible claims, and services not covered by the plan. In comparison to the Standard Plan, the SMP plan members contributed only 0.7% in out-of-pocket costs. The SMP plan does have some out-of-pocket costs in the form of ER Copays, coinsurance on DME and Outpatient Psychiatric Visits. The total seen in the copayment segment is not just ER copays but also encompasses coinsurance amounts that do not apply to the annual out-of-pocket maximum for a member.

For the **Medicare Carve-out Plan**, WPS paid 5.6% of submitted charges on behalf of the plan. Payments made by Medicare have an overwhelming impact on savings by accounting for 76.7% of the submitted charges. The second highest savings percentage, 13.8%, came from the rejection of duplicate or non-eligible charges. This percentage has decreased from 17.4% in 2006. The decrease is the result of a WPS Claims Department provider education initiative regarding optimal methods of claim submission.

As seen in the pie chart in Exhibit 16-D, the total payment made by WPS for all plan types in 2006 was 11.4% of submitted charges. With the Medicare population's impact, 70.2% of the savings was provided by Medicare, followed by 13.0% in rejections for duplicates and non-eligible services.

Exhibit 17-C

WISCONSIN PUBLIC EMPLOYERS
Medical Claim Savings Analysis
Incurred January 2007 - December 2007 Paid Through March 2008

Category	STANDARD		SMP		MEDICARE	
	$ Amount	% of Total	$ Amount	% of Total	$ Amount	% of Total
Submitted Charges	**$544,613.56**	**100.0%**	**$232,015.29**	**100.0%**	**$8,442,023.28**	**100.0%**
Duplicates/Not Eligible	**$19,986.21**	**3.7%**	**$16,604.03**	**7.2%**	**$1,160,977.75**	**13.8%**
Pricing Cutbacks	**$56,135.80**	**10.3%**	**$22,697.74**	**9.8%**		
Out-of-Pocket						
Deductible	$14,428.56	2.6%	$931.72	0.4%	$40,783.92	0.5%
Coinsurance	$10,819.17	2.0%	$694.40	0.3%	$80,500.90	1.0%
Copayments	$1,223.50	0.2%	$47.62	0.0%	$1,268.26	0.0%
Total	**$26,471.23**	**4.9%**	**$1,673.74**	**0.7%**	**$122,553.08**	**1.5%**
Not Covered						
Medical Necessity	$2,973.31	0.5%	$0.00	0.0%	$1,582.52	0.0%
Inappropriate Provider	$0.00	0.0%	$0.00	0.0%	$523.00	0.0%
Benefit Maximum	$1,087.68	0.2%	$2,360.00	1.0%	$52,504.55	0.6%
Experimental/Fertility	$582.00	0.1%	$0.00	0.0%	$369.00	0.0%
Dental	$468.00	0.1%	$0.00	0.0%	$510.00	0.0%
Custodial	$0.00	0.0%	$0.00	0.0%	$45,980.00	0.5%
Code Review	$16,354.00	3.0%	$1,856.80	0.8%	$2,020.83	0.0%
Contact Lens/Hearing Aid	$133.96	0.0%	$0.00	0.0%	$1,361.29	0.0%
Drugs	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%
No Referral	$0.00	0.0%	$13,232.83	5.7%	$0.00	0.0%
All Other	$1,341.43	0.2%	$3,267.27	1.4%	$107,391.19	1.3%
Total	**$22,940.38**	**4.2%**	**$20,716.90**	**8.9%**	**$212,242.38**	**2.5%**
Third Party Liability						
Workers Compensation	$0.00	0.0%	$225.00	0.1%	$3,458.88	0.0%
Subrogation	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%
Coordination of Benefits	$406.41	0.1%	$482.82	0.2%	$0.00	0.0%
Total	**$406.41**	**0.1%**	**$707.82**	**0.3%**	**$3,458.88**	**0.0%**
Medicare	**$3,756.38**	**0.7%**	**$0.00**	**0.0%**	**$6,472,217.57**	**76.7%**
Payments	**$414,917.15**	**76.2%**	**$169,615.06**	**73.1%**	**$470,573.62**	**5.6%**

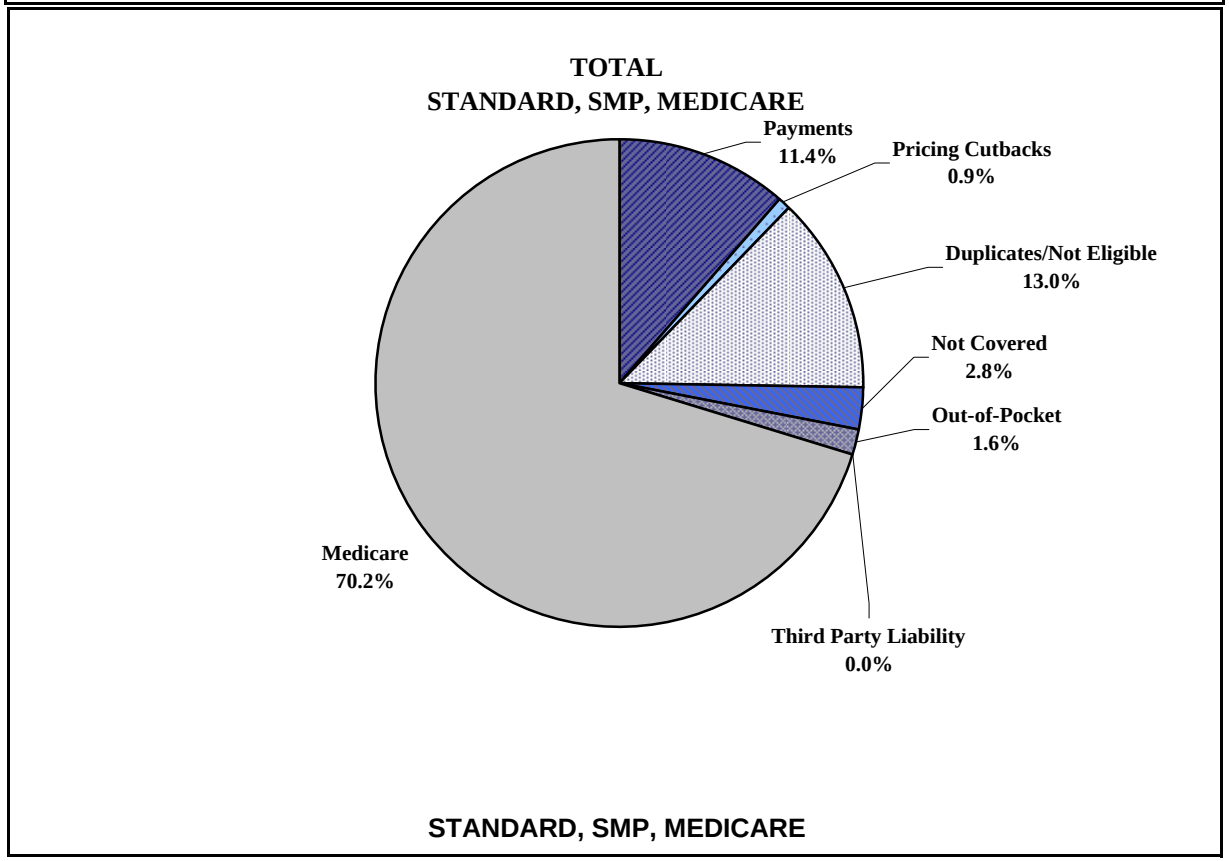
Exhibit 17-D

WISCONSIN PUBLIC EMPLOYERS

Medical Claim Savings Analysis Summary

Incurred January 2007 - December 2007 Paid Through March 2008

	STANDARD		SMP		MEDICARE	
	$ Amount	% of Total	$ Amount	% of Total	$ Amount	% of Total
Payments	$414,917.15	76.2%	$169,615.06	73.1%	$470,573.62	5.6%
Pricing Cutbacks	$56,135.80	10.3%	$22,697.74	9.8%		
Duplicates/Not Eligible	$19,986.21	3.7%	$16,604.03	7.2%	$1,160,977.75	13.8%
Not Covered	$22,940.38	4.2%	$20,716.90	8.9%	$212,242.38	2.5%
Out-of-Pocket	$26,471.23	4.9%	$1,673.74	0.7%	$122,553.08	1.5%
Third Party Liability	$406.41	0.1%	$707.82	0.3%	$3,458.88	0.0%
Medicare	$3,756.38	0.7%	$0.00	0.0%	$6,472,217.57	76.7%



WPS HEALTH INSURANCE

State of Wisconsin

Section 3: Integrated Care Management

Insuring **Wisconsin's** Health *Since 1946*

State Employee Trust Funds

Executive Summary

- Costs compared to benchmarks are high (PMPM) in three diagnostic categories including cancer, behavioral health, and obesity.

- Bariatric Surgery costs continue to contribute to a high PMPM in the obesity category, but no cases were in the high dollar report.

- Mammography screening rates are above the national average.

- Cervical cancer rates are below the national average, but the optional exclusion for members with a hysterectomy was not taken and the denominator maybe inflated.

- There are 42 ETF members with claims over $100K.
  - Care Management services were provided to 100% of these high dollar members
  - Cancer accounted for 40% of these high dollar cases

- 86 members were opened to Chronic Condition Management in 2007.
  - 60% had cardiac (including hypertension) diagnoses
  - 37% were members with diabetes

- Clinical Quality measures for Diabetic Care were below the National average. There is an opportunity to engage more members with diabetes in chronic condition management in 2008.

- Care Management savings for Utilization Management, Outpatient Prior Authorization, Case Management, and Medical Review was $2.3 million, a 12 % increase over 2006.

- Comprehensive WPS Wellness program was launched in 2008, including numerous free health resources for consumer education.

Integrated Care Management: The Paradigm has changed

- **Coordination of services across the healthcare continuum from healthy to "sick"**

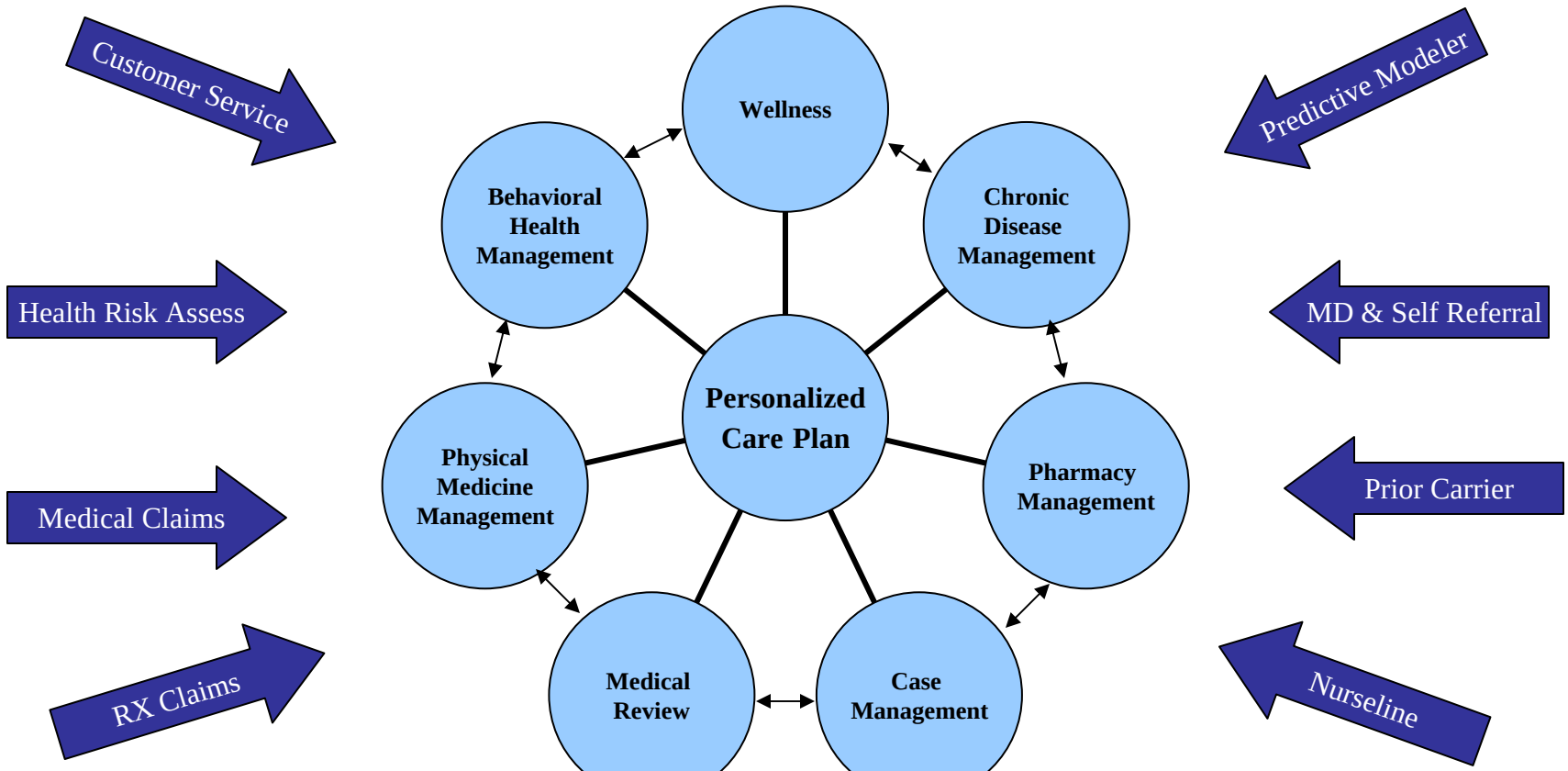
  - Wellness and Lifestyle Management – Wellness Coaches
  - Chronic Condition and Targeted Health Conditions – Chronic Condition Managers
  - Acute Episode, Complex and High Dollar Cases – Case Managers

- **Philosophy and Goals**

  - Empower members as consumers of care
  - Improve health care outcomes with efficient cost effective delivery of care
  - Member focused and quality-oriented interventions

Exhibit 1

Integrated Care Management



Obesity and Bariatric Surgery

- PMPM costs were high compared to the benchmark.
- No obesity related diagnoses were found in the high dollar claims report in 2007.
- The report that follows provides information about Bariatric Surgery Centers including 2007 cost differences between Bariatric Centers of Excellence and non-Centers of Excellence.

ETF Bariatric Procedures

ETF Bariatric Surgery History

In 2006 and 2007, ETF covered bariatric surgery for members in the WPS Standard Plan who met the medical necessity criteria in the WPS Bariatric Surgery Medical Policy. The Lap Band technique was not covered during 2006, but this coverage was added in 2007. Criteria for coverage of the Lap Band procedures are the same as the criteria for other bariatric procedures.

In 2007, based on concern about the variation in the cost of bariatric surgery and related complications, ETF asked WPS to create a Center of Excellence approach for Bariatric surgeries. The ETF Bariatric programs (hospital and surgeon combinations) are certified by CMS and the America Society of Bariatric Surgeons as a Center of Excellence (COE).

In response, WPS contracted in 2008 with the following programs that meet the COE criteria:

Aspirus Wausau Hospital, Wausau, WI
Bellin Health, Green Bay, WI
Columbia-St. Mary's, Milwaukee, WI
Elmbrook Memorial Hospital, Brookfield, WI
Froedtert Memorial Hospital, Milwaukee, WI
Gundersen Lutheran Medical Center, LaCrosse, WI
Meriter Hospital, Madison, WI (as part of UW designation - same surgeons)
Theda Clark Medical Center, Neenah, WI
University of Wisconsin Hospital, Madison, WI

ETF Bariatric Procedure Data

The following data summarizes and compares case costs using the Center of Excellence (COE) approach and Paid per Member per Month (PMPM) procedure costs. A comparison to a WPS book of business is also provided.

Although the numbers are small, it appears there maybe an economic advantage for ETF to continue pursuing a bariatric procedure center of excellence approach. ETF's PMPM is greater than WPS's book of business PMPM, and contributing factors are discussed.

Exhibit 2

STATE EMPLOYEE TRUST FUNDS
Bariatric Cost Per Case and PMPM
Incurred January 2007 - December 2007 Paid Through March 2008

	INPATIENT Bariatric Procedures		OUTPATIENT Bariatric Procedures	
	ETF	**WPS**	**ETF**	**WPS**
Center of Excellence				
Cost/Case (# of cases)	$30,172 (13)	$35,566 (18)	$14,578 (2)*	$21,258 (3)**
LOS	1.62	2.28	N/A	N/A
Non-Center of Excellence				
Cost/Case (#of cases)	$37,261 (9)	$33,230 (33)	$23,980 (4)	$14,960 (9)***
LOS	2.22	3.12	N/A	N/A
Combined Cost/Case (total # of cases)	$33,072 (22)	$34,054 (51)	$20,846 (6)	$16,535 (12)
Average LOS	1.86	2.82	N/A	N/A
Total Member Months	46,800	512,970	46,800	512,970
Incidence (patients/1000)	5.64	1.19	1.28	0.28
Total PMPM	$15.55	$3.39	$2.66	$0.39

Note: Costs calculated based on allowed amount.

Note: Book of WPS members with bariatric surgery benefit excludes ETF members. Costs did not include two outlier cases.

*** One case was a revision of a previously placed lap band, not the initial procedure.**

**** All procedures performed in hospital outpatient setting.**

***** Several surgeries performed at surgical centers.**

ETF Bariatric Procedures

Summary

- ETF's 2007 inpatient cost per case was almost 20% less at a COE when compared to a non-COE facility, and clearly demonstrates the economic advantage of a COE approach to bariatric surgery.

- ETF's 2007 outpatient cost per case was almost 40% less at a COE when compared to a non-COE. However outpatient data is limited to six cases and one of the COE procedures was a lap band revision (five members with six outpatient procedures).

- Cost per case for outpatient procedures is impacted by the treatment setting. Outpatient cost per case is less at surgical centers when compared to hospital based outpatient procedures, and provides ETF an opportunity for savings when lap band procedures are performed at surgical centers. These savings are driven by lower facility costs at surgical centers.

- ETF's 2007 PMPM is greater than the book of WPS members with a bariatric surgery benefit. Factors influencing these higher costs include:

    - 2007 ETF total incidence rate of 6.92 for bariatric surgery is almost five times the WPS book of business total incidence rate of 1.47 for bariatric surgery.
    - Fewer ETF members to allocate costs when compared to book of WPS business.
    - ETF members may use the WPS plan exclusively for bariatric procedures resulting in adverse selection. Many ETF members dis-enroll from the WPS plan at the end of the year following their bariatric procedure. During 2006, twenty five ETF members had bariatric surgery and 80% (20/25) termed with WPS by January 1, 2008. For 2007, twenty seven ETF members had twenty eight bariatric procedures and 41% (11/27) termed with WPS as of January 1, 2008.

Conditions Managed for High Cost Cases

- Behavioral health (MDC 19) PMPM was high compared to the benchmark.
- Inpatient behavioral health admissions appear to be responsible for this difference, and two members with Behavioral Health diagnoses accounted for 5% of the total high cots members (over $100,000).
- Cancer accounted for 40% (17/42) of high dollar cases and 49% of total high dollar claims.
- Breast cancer was the most prevalent type of cancer, accounting for 35% (6/17) of high dollar cancer diagnoses.
- All members with high dollar claims received intensive care management services.

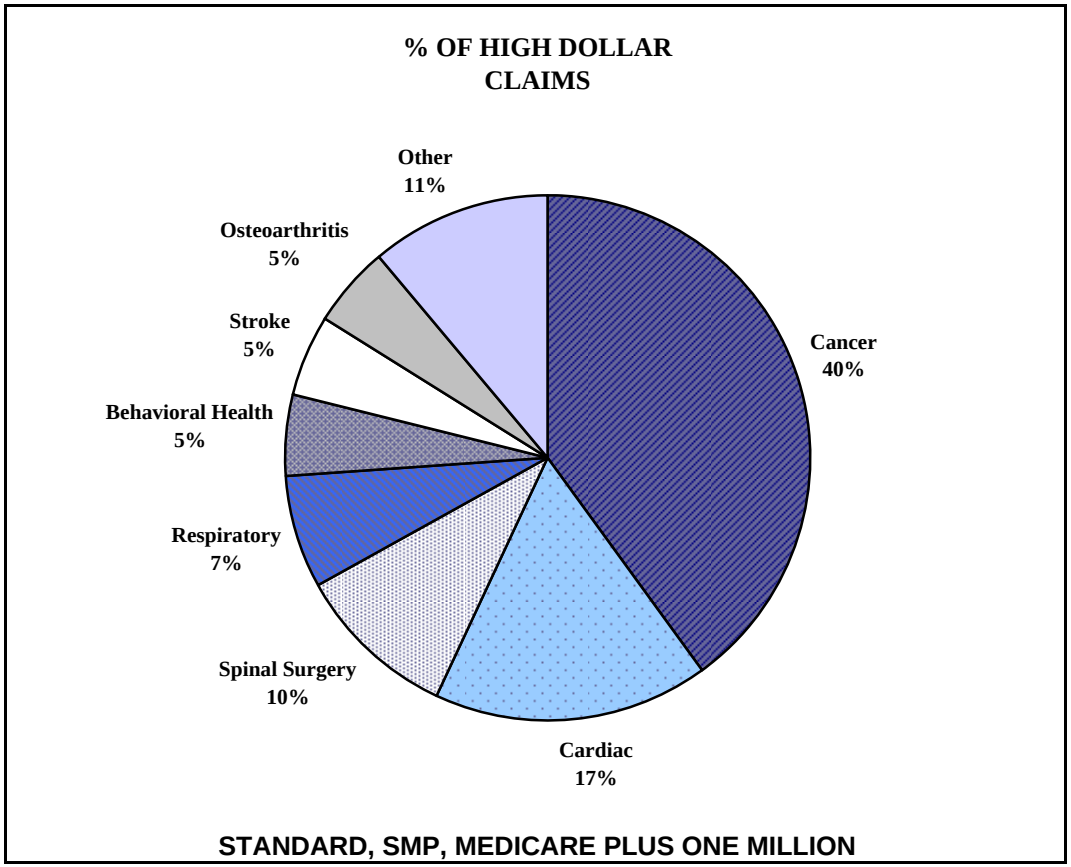
Exhibit 3

STATE EMPLOYEE TRUST FUNDS

Claims by Diagnosis

Incurred January 2007 - December 2007 Paid Through March 2008

Diagnosis	% of High Dollar Claims	% of Total Claims
Cancer	40.0%	49.0%
Cardiac	17.0%	16.0%
Spinal Surgery	10.0%	7.0%
Respiratory	7.0%	5.0%
Behavioral Health	5.0%	6.0%
Stroke	5.0%	6.0%
Osteoarthritis	5.0%	3.0%
Other	11.0%	8.0%



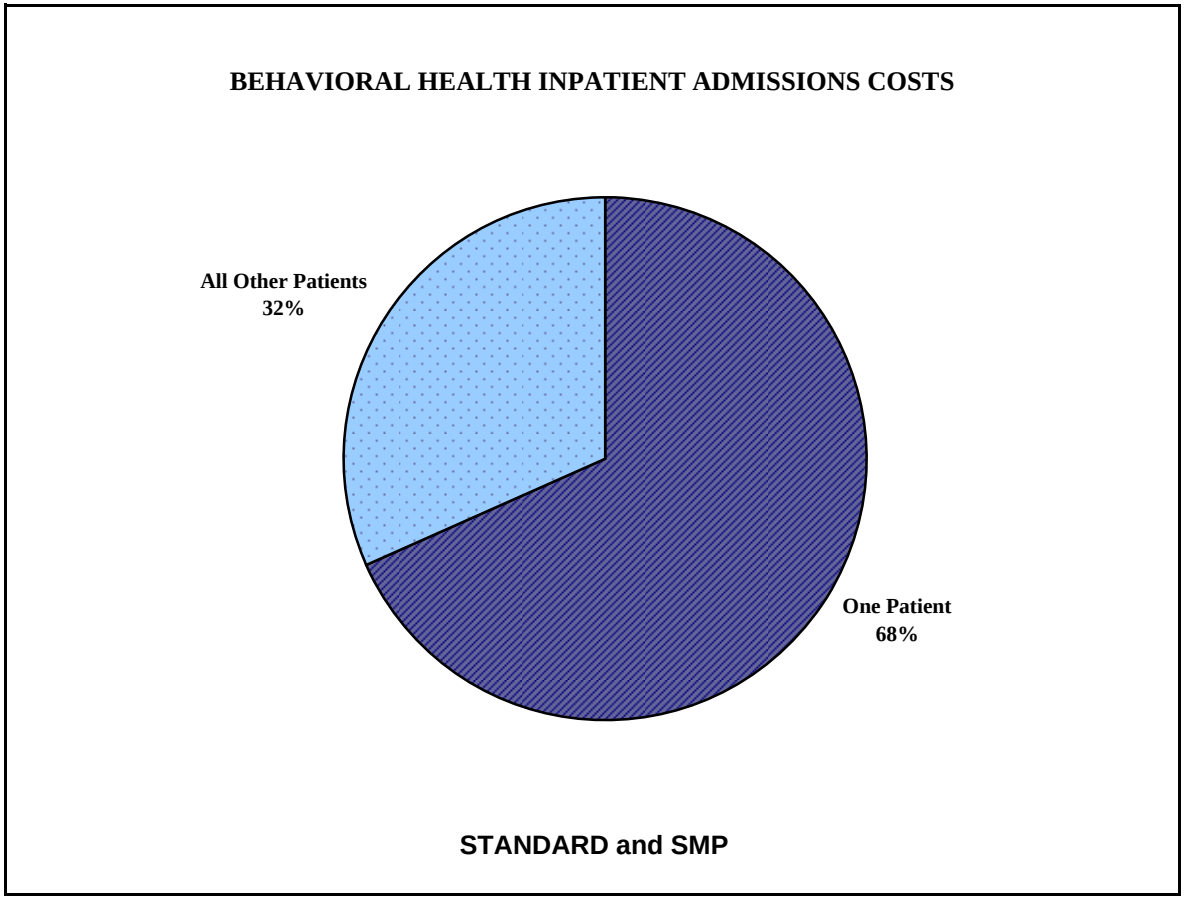
Behavioral Health Findings

- **Behavioral Health Management** provides both inpatient as well as outpatient reviews which are performed by individuals specifically licensed in the behavioral health field. All managed care services, including utilization management, case management, disease (chronic condition) management, and pre-authorization are performed by this team.
- Only 22 behavioral health inpatients admissions for ETF members in 2007.
- Behavioral health admissions represented 1% of total paid claims and 6% of high dollar claims (over $100K).
- One admission was 68% of inpatient behavioral health claims. This outlier admission occurred in early Q2; all days certified by MD psychiatric physician advisor; member case managed by one of our licensed clinical social workers. Member had an additional 45 day stay in Q4; claim recently received and not processed yet. Anticipate ongoing care and possible high costs for this member.
- Increase in PMPM cost for behavioral health was primarily due to this one outlier case.

Exhibit 4

STATE EMPLOYEE TRUST FUNDS
Behavioral Health Inpatient Admissions
Calendar Year 2007

	Paid Claims
One Patient	$304,000
All Other Patients	$141,000



Care Management Services

Case Management is assessing, planning and facilitating services for members involved in an acute or catastrophic medical situation. The Case Manager focuses on managing the utilization of benefits within the confines of the policy, in the most effective manner; ensuring quality of care is not compromised. Examples of Case Management are inpatient rehabilitation cases, long term inpatient cases, or short term home care cases that require skilled nursing visits and/or intravenous (IV) therapy. All of these cases are closely managed by the case manager.

Chronic Condition (Disease) Management utilizes a proactive approach through education, treatment and appropriate care to prevent long-term and unnecessary complications of chronic conditions. Through education, the Chronic Condition Manager empowers members to take ownership of their health, decreasing future health risks, minimizing the need for medical services, and ultimately, improving the quality of life.

Medical Review is an additional process in the Medical Affairs area that does post-claim review to ensure that those services that received prior approval are billed appropriately, and /or that services billed are covered by the member's plan, and are medically necessary.

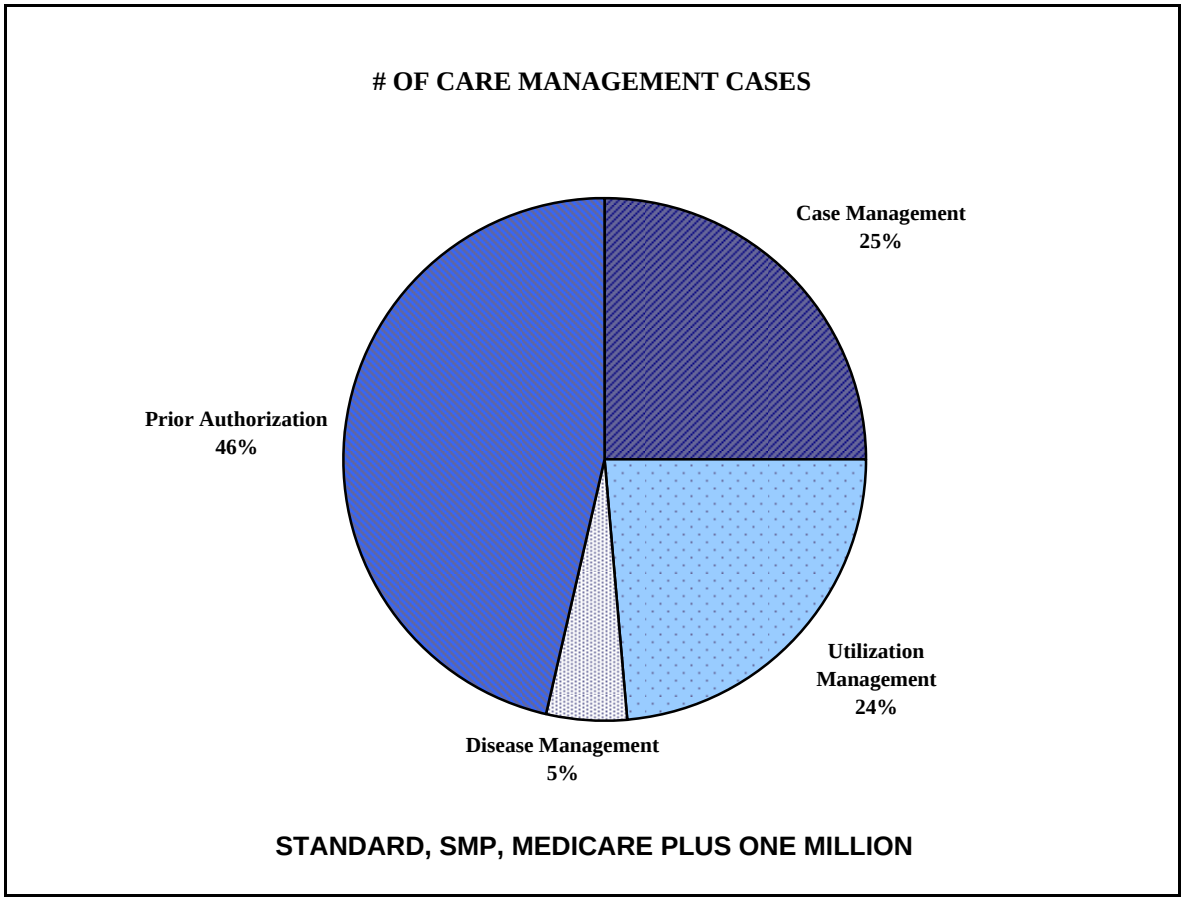
Preauthorization is the review of specific outpatient services, including surgical services, diagnostic services, and referral, and determination that these services meet the criteria for medical necessity under the member's benefit plan.

Utilization Management helps ensure members achieve proper utilization of services, while maximizing their health care benefits, as well as determining the most appropriate level of care. Care Management nurses monitor patient care through preadmission or pre-certification review, inpatient admission and concurrent review, discharge planning with referrals to Case or Disease management nurses and outpatient services review.

Exhibit 5

STATE EMPLOYEE TRUST FUNDS
Care Management Summary
Calendar Year 2007

Care Management Category	# of Cases
Case Management	430
Utilization Management	405
Disease Management	86
Prior Authorization	797



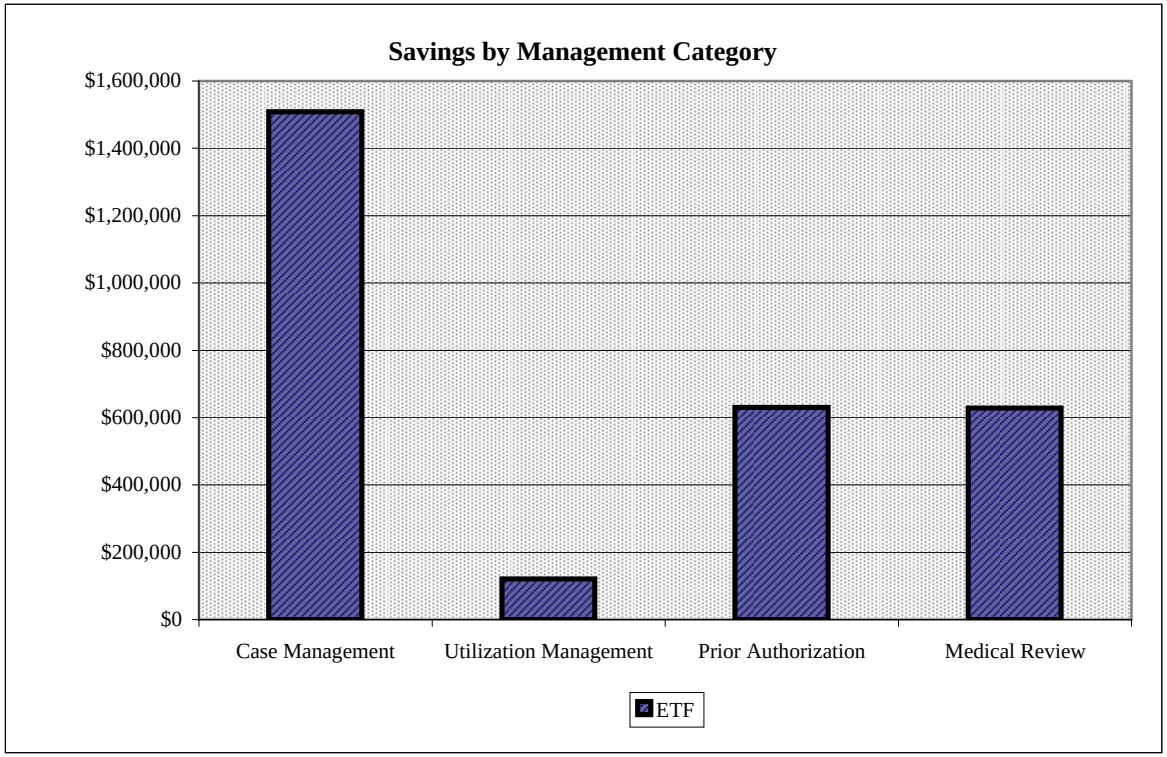
Care Management Savings

- In 2007, WPS Care Management saved ETF almost $2.3 million dollars, an increase of 12% compared to 2006.
- Savings are based on avoided hospital days, avoided/denied services, or negotiated rate reductions.
- Only hard savings are included – projected future (soft savings) from Chronic Condition (Disease) Management are not calculated.
- Not all Case Management results in dollar savings based on the above definition. Many cases are followed so that the most cost effective care possible is provided – for example a potential transplant case that is kept open for several months.

Exhibit 6

STATE EMPLOYEE TRUST FUNDS
Care Management Savings
Calendar Year 2007

Care Management Category	Savings
Case Management	$1,508,880
Utilization Management	$120,329
Prior Authorization	$630,748
Medical Review	$628,403



Health Status Measures – HSM

Health Status Measures (HSM) are a predictor of members at risk for additional care and related costs. Our predictive modeling tool helps improve the effectiveness and productivity of our case and disease managers by identifying at-risk members before their conditions and costs escalate. This enables us to enroll members in Case and Chronic Condition Management programs at a much earlier stage.

The software uses multiple technologies, including severity indices. One of these indices, Burden of Illness (BOI), ranks members based on severity and complications. These scores are categorized into HSM's. Members with high scores of 7 to 10 are identified and screened for chronic condition management. Those with low HSM scores are provided self management guides via quarterly mailing.

Exhibit 7

STATE EMPLOYEE TRUST FUNDS

HSM Table

Calendar Year 2007

HSM Severity Score	Members with			
	Asthma	Diabetes	Hypertension	Heart Disease
10	2	3	2	2
9	2	3	1	1
8	2	6	8	4
7	4	6	9	2
6	3	7	9	3
5	14	25	48	12
4	27	55	105	16
3	32	34	141	14
2	38	38	134	13
1	55	51	139	12
Total	**179**	**228**	**596**	**79**

Chronic Condition (Disease) Management

The Chronic Conditions managed for ETF are: Asthma, Congestive Heart Failure, Coronary Artery Disease (which includes Hypertension and High Cholesterol), Diabetes, Neonatal, Alcohol & Drug Abuse, & Depression. (Note: Members enrolled in the Great Beginnings High Risk Prenatal program were managed under Case Management in 2007).

New in 2008, is our opt-out program. Members identified for case or disease management are offered the opportunity to participate in our program and must decline either verbally or in writing if they chose not to participate.

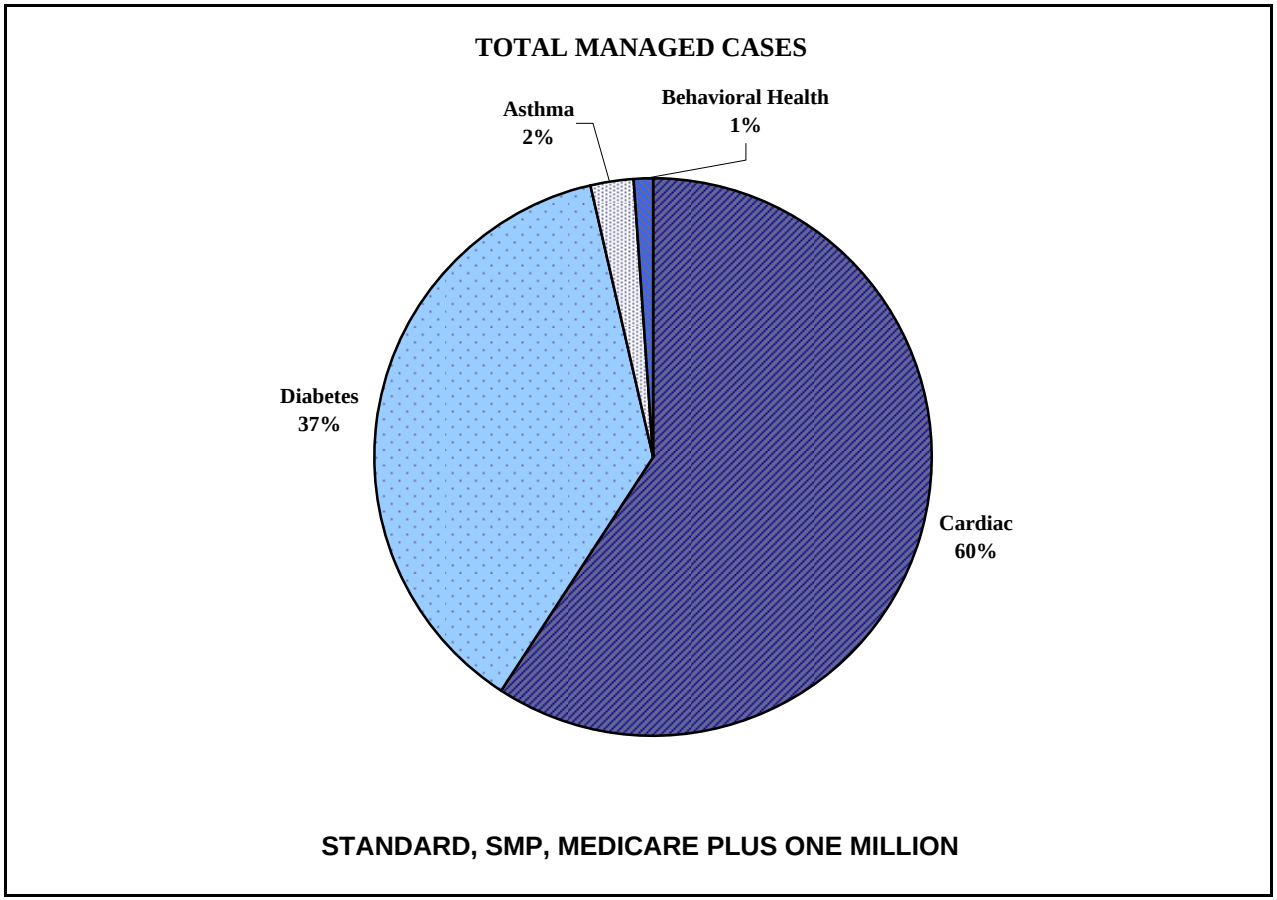
The Chronic Condition Management process starts with an introductory letter followed by two phone contacts. If member has no listed phone number, a second letter is sent. If no response from the member to opt-out, they are transferred to our mailing queue and receive disease specific information on a quarterly basis.

In 2007, ETF members with cardiac and diabetic conditions received the majority of our chronic condition management services.

Exhibit 8

STATE EMPLOYEE TRUST FUNDS
Chronic Conditions - Managed Cases
Calendar Year 2007

Chronic Conditions	Open Cases	Closed Cases	Total Cases
Cardiac	21	30	51
Diabetes	10	22	32
Asthma	0	2	2
Behavioral Health	0	1	1



Quality Measures for Chronic Conditions and Health Screening

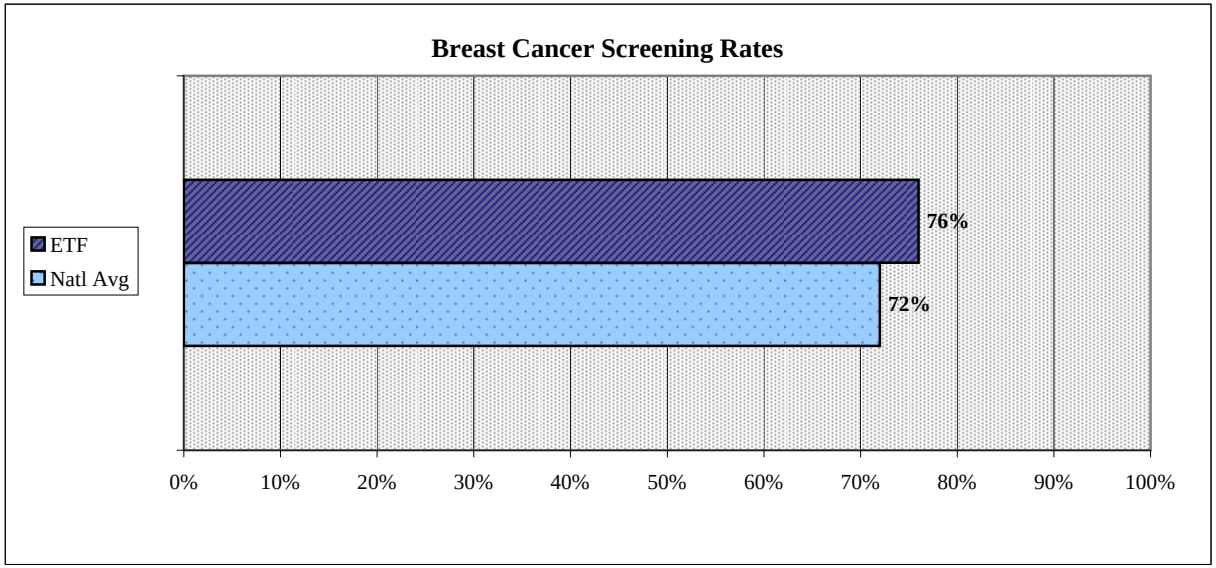
- Performance measures provide information about a provider's quality of clinical care. New for 2007 were a limited number of quality measures for preventive health screening and chronic condition management.
- The breast cancer screening rate for women ages 52 to 69 who received a mammogram within the past two years (2006-2007) was above the national average.
- Screening rate for cervical cancer for women ages 21 to 64 who received a Pap test within the past two years (2006-2007) was below the national average; however the optional exclusion for women who had a hysterectomy was not taken, and the denominator maybe overstated.
- Quality measures for ETF's diabetic population included rates for HbA1c and LDL-C testing in 2007. These screening rates were below the national average, and provide an opportunity for improving the effectiveness of care for diabetic members.
- Opportunities to provide quality measures is currently limited, but additional quality measures for chronic conditions and preventive health screening will be available for 2008 data. A partial listing of these quality measures is included.

Exhibit 9-A

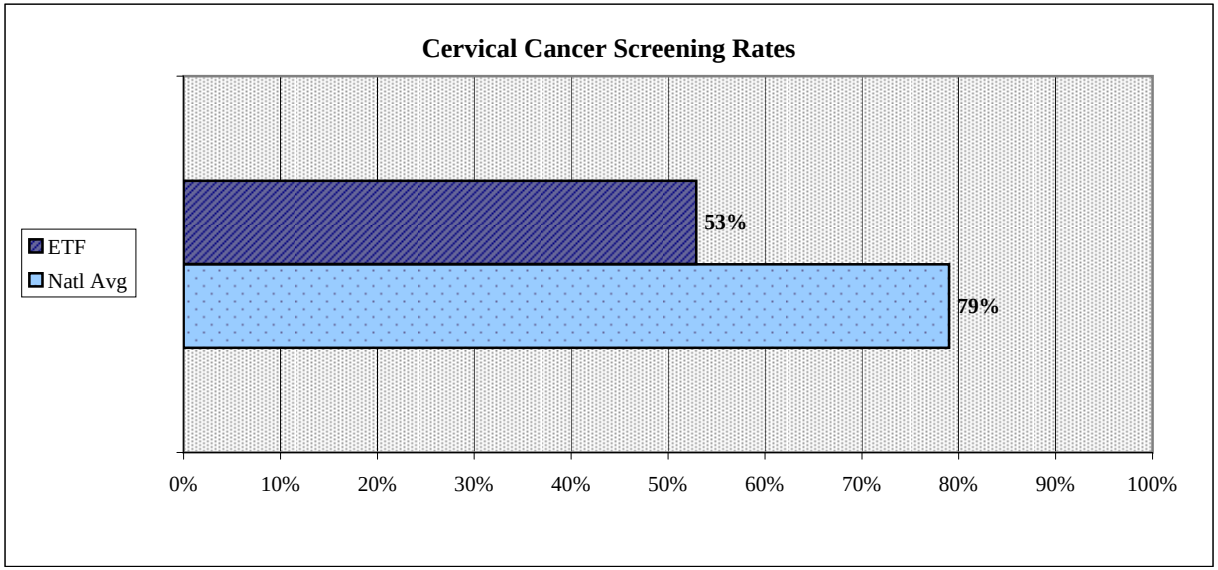
STATE EMPLOYEE TRUST FUNDS

Screening Rates

Calendar Years 2006 and 2007



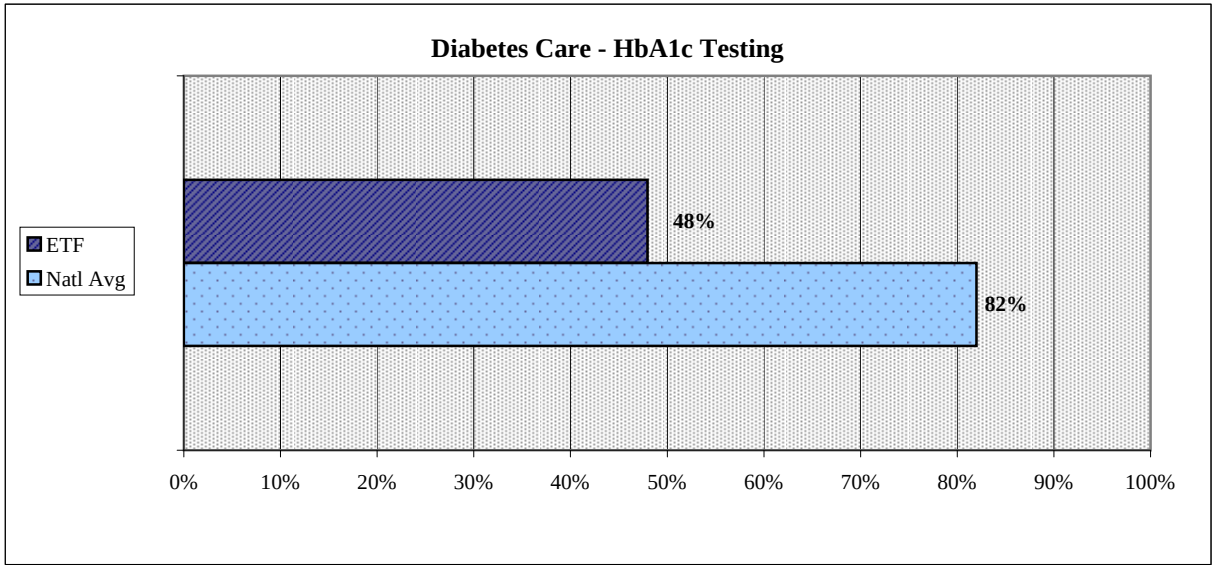
*** Percentage of Women Ages 52-69 with a Mammogram in 2006 or 2007**



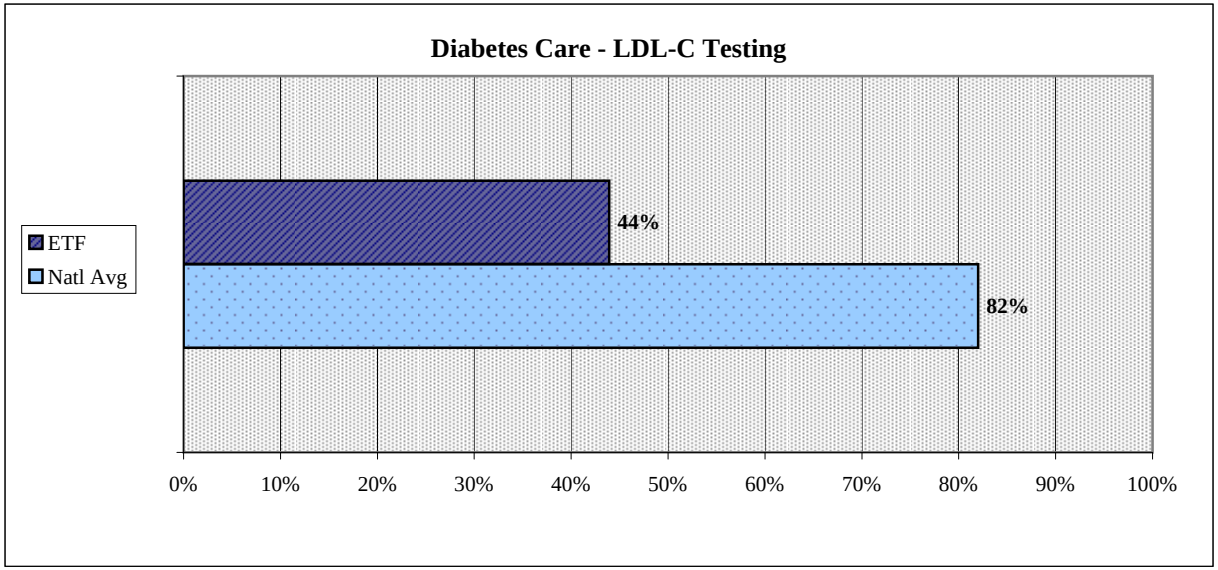
*** Percentage of Women Ages 21-64 with a Pap Test in 2006 or 2007**

Exhibit 9-B

STATE EMPLOYEE TRUST FUNDS
Diabetes Measures
Calendar Year 2007



*** Percentage of Diabetics ages 18-75 with a HbA1c Test in 2007**



*** Percentage of Diabetics ages 18-75 with an LDL-C Test in 2007**

Available Quality Measures (Partial Listing)

Asthma Care Management:

- Members 5-40 years old with an office visit for asthma care in the last 12 reported months (or 6 months).
- Members with presumed persistent asthma.
- Members with presumed persistent asthma using an inhaled corticosteroid or acceptable alternative.
- Members exhibiting problematic asthma control who had a specialty consult in last 12 months.
- Members taking theophylline with annual serum theophylline level test.
- Members using a long-acting beta2-agonist inhaler in combination with an inhaled corticosteroid.
- Members compliant with theophylline (compliance >= 70%).
- Members compliant with leukotriene modifier (compliance >= 70%).

Cardiovascular Care Management:

- CAD Members hospitalized with acute myocardial infarction taking a beta-blocker at admission or within 7 days of discharge.
- CAD Members with prior myocardial infarction prescribed beta blocker during measurement year.
- CAD Members with myocardial infarction in the past currently on beta blockers.
- CAD Members with an LDL cholesterol test in the report period.
- CHF Members prescribed ACE-inhibitor or angiotensin II receptor antagonist treatment during measurement year.
- CHF Members currently taking an ACE-inhibitor or acceptable alternative.
- CHF Members prescribed beta-blocker therapy during measurement year.
- CHF Members currently taking a beta-blocker.

Note: Quality measures available first quarter 2009, for 2008 data.

Care Management Satisfaction

Satisfaction Rating: 97%

Satisfaction Survey Comments:

- This was an excellent, highly professional, and personally friendly service - much appreciated!
- Carla was the most professional, compassionate, knowledgeable, yet always an advocate for the best possible solution for my care within the insurance guidelines. She is a true gem.
- I was very impressed that this service is provided and with the quality and personal attention provided.
- Our care manager, Rhonda, was extremely professional and proficient. She went out of her way to help us through this stressful time.
- What a wonderful service your insurance company provides! Rosalynn was my biggest cheerleader and is one of the reasons I made such wonderful progress. Rosalynn also provided me with pamphlets and reading material to maintain a healthy heart. I have never had an insurance company that followed my care postop. All I can say is that it is a great program to provide for those you insure. My thanks!
- Ann was outstanding! She was an amazing support! She called to check on me often, I truly appreciated her guidance and support. Wonderful program!!
- Virgie, I cannot thank you enough, you saved my life. I want to thank you in greater detail when I can.

Wellness and Prevention Programs

Included in the WPS Integrated Care Management programs is a Comprehensive Wellness initiative that was launched in 2008.

Available at no additional charge through the WPS member portal are:

A ***free online health encyclopedia*** from Healthwise. The Healthwise® Knowledgebase contains more than 3,200 evidence-based topics on health conditions, medical tests and procedures, medications, and everyday health and wellness issues.

HealthSense Rewards™, a WPS program that provides discounted access to a variety of health clubs, weight-management centers, and other wellness resources.

Health and Wellness Newsletter (PDF versions or disc) are on a bi-monthly basis ***available through the WPS Member Health Center portal***.

Health and Wellness Community Resource Guide (PDF versions or disc) that refers ETF employees to approximately 200 local organizations, helping you to further enhance your worksite wellness program.

Weekly / Monthly email Wellness Tips (available on disc or word document) specific to ETF needs (Nutrition and Weight Management, General Wellness and/or Physical Activity)***.***

Wellness Services available at cost:

Health Risk Appraisal
This is available on-line or in paper format. Administered by WPS Wellness staff and provided through Staywell. WPS Staff will present the results in an aggregate form as well as individually to the employees during a 10-15 minute coaching session. ***This is offered for an additional fee based on whether it is online or paper.***

Biometric Screening ***This service is billed at cost and arranged through local providers.***

Wellness Coaching Sessions
Telephonic and on-line wellness coaching sessions can be purchased for an additional fee.

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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

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

CORRESPONDENCE MEMORANDUM

DATE: May 23, 2008

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans
Joan Steele, Manager, Alternate Health Plans

SUBJECT: Guidelines and Uniform Benefits for the 2009 Benefit Year – Technical Changes

At its April 15, 2008, meeting, the Group Insurance Board (Board) reviewed and approved changes for the 2009 benefit year. In addition, the Board granted staff the authority to proceed with any needed technical clarifications. The following is a brief description of those technical clarifications and corresponding language changes. New language is shaded and underscored and language to be deleted is ~~stricken~~.

Section	Technical Clarification	Language Change
State & Local Contract *Article 1.7* *and* Uniform Benefits *Section II.*	Language explaining the support test was clarified. In addition, language was added to clarify that "student" is defined in the ETF Administrative Code.	. . . . A Dependent child must be dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated ~~on~~ by the support test~~s as a Dependent~~ for federal income tax purposes, whether or not the child is claimed. . . . Student status includes any intervening vacation period if the child continues to be a full-time student. As defined in Wis. Adm. Code § ETF 10.01 (5), s~~S~~tudent means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue ~~Service~~ Code, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

Signature _____ Date _____

Board	Mtg Date	Item #
GIB	6/10/2008	4

Section	Technical Clarification	Language Change
State & Local Contract *Article 2.5 (2)*	Reduced the per member per month from health plans for the costs of informational materials, such as the "It's Your Choice" booklet and "It's Your Benefit" newsletter.	. . . The vendor shall be reimbursed by the HEALTH PLAN at cost, but not to exceed $.069 per member per month.
State & Local Contract *Article 3.4 (5)*	Language was clarified to reflect that by contract, the ability to change health plans upon meeting or exceeding the benefit lifetime maximum is extended to annuitants, even though Federal law does not require it.	As required by Federal law, an EMPLOYEE, ANNUITANT or CONTINUANT may change HEALTH PLANS if a claim is incurred by an individual covered under the policy that would meet or exceed the lifetime maximum BENEFITS. This also applies to ANNUITANTS as if Federal law required it. An application must be filed during the 30-day period after a claim is denied due to the operation of a lifetime limit on all BENEFITS with coverage effective on the first day of the month on or following receipt of the application.
State & Local Contract *Article 3.4 (7)*	Language was clarified to reflect that by contract, the ability to change health plans when adding a dependent(s) following certain events is extended to annuitants, even though Federal law does not require it.	As required by Federal law, an insured EMPLOYEE, ANNUITANT or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, birth, adoption, placement for adoption, loss of other coverage or loss of employer contribution for the other coverage may change HEALTH PLANS after the event if an application is submitted within 30 days of the event. This also applies to ANNUITANTS as if Federal law required it. Coverage with the new HEALTH PLAN will be effective the first day of the calendar month, which begins on or after the date the EMPLOYER receives the application selecting the new HEALTH PLAN.
Uniform Benefits *Section II.*	In response to questions raised by a Board member at the last meeting, the intent of holding the member harmless from third party (e.g., non-plan providers) collection efforts has been clarified.	. . . services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must while holding 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.

Section	Technical Clarification	Language Change
Uniform Benefits *Section III., A., 1., b. & 2., b.*	In response to questions raised by a Board member at the last meeting, it has been clarified that prior authorizations pertain to the follow-up 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.

Staff will be available at the Board meeting to respond to any questions or concerns.

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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

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

CORRESPONDENCE MEMORANDUM

DATE: May 27, 2008

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans
Arlene Larson, Manager, Self-Insured Health Plans

SUBJECT: WPS Recommendations for Benefit Clarifications and Changes to the Standard Plans Group Health Insurance Program Effective January 1, 2009

The purpose of this memo is to discuss the proposals for Group Insurance Board (Board) action on the Standard Plans. Wisconsin Physician's Service Health Insurance (WPS) has suggested a few changes to the contract that may make the plan more specific and easier to understand. In addition, staff recommends that provisions of the Medicare Plus $1,000,000 plan be altered (e.g. adding immunizations), as requested by some members.

WPS has provided a grid of the proposed changes (see attached). This document details the suggestions and explains WPS's rationale for each item. In addition to the WPS grid, relevant portions of the *Professional Administrative Services Agreement* (PASA) and *Health Benefit Plan* (HBP) contract are attached with new material highlighted and material being proposed for deletion ~~stricken~~. Changes that the Board previously approved in the Guidelines that apply to the Standard Plans are being made in this contract, but those pages are not shown here.

As staff works with WPS on its administration of the benefit plan, we will continue to refine these provisions and bring them back to the Board as necessary.

Action requested:

Staff requests Board action on these changes in order to finalize the Standard Plans contract for 2009.

1. **Staff recommendation to add immunizations to the Medicare Plus $1,000,000 plan and modify the skilled nursing facility benefit to be consistent with Uniform Benefits.**
2. **Staff recommendation that the Board approve clarifications and reasonable updates to the Standard plan and overall contract (see items 2 through 4 below).**
3. **Giving staff the authority to include any changes to the draft following input from the Board and for any technical issues that may arise thereafter.**

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	06/10/2008	4

Discussion of proposed changes:

Following Board discussion and approval, staff will incorporate any changes suggested by the Board and finalize the contract with WPS in order to allow for member notification prior to the Dual-Choice period. Final formatting of the contract text will be submitted to the Board chair for signature.

1. *Benefit changes to the Medicare Plus $1,000,000 plan*

   Every year some members of this plan contact the Department and the plan administrator to request coverage for preventive services such as immunizations and routine care. Typically these calls come from those who were previously enrolled in Health Maintenance Organizations (HMOs) and are accustomed to routine care benefits. The Medicare Plus $1,000,000 plan supplements Medicare, which covers the treatment of illness or injury, but not preventive care.

   The Department has received many requests to cover immunizations. The shingles vaccine, in particular, has been an issue, since it is covered by all plans that offer Uniform Benefits. Medicare Part B allows coverage of the vaccines for the prevention of influenza, hepatitis B and pneumonia. Medicare Part D plans can cover shingles in some cases, but this does not work well with our current Navitus RDS subsidy. Currently, the Medicare Plus $1,000,000 plan specifically excludes coverage for all immunizations and they are not considered by WPS to be the treatment of an illness or injury.

   Deloitte has provided a cost of $.30 per member per month (PMPM) to add comprehensive immunization coverage to this plan.

   To offset this cost, staff is recommending that the skilled nursing facility benefit be made equal to that in the Uniform Benefits plan. Currently, the Medicare Plus $1,000,000 skilled nursing facility benefit has no day limit for medically necessary care. The benefit does not cover custodial care. Uniform Benefits allows coverage for up to 120 days per benefit period or spell of illness. A benefit period is a standard designation under Medicare equal to the total duration of all confinements that are separated from each other by less than 60 days. Spell of illness is an older term that has been used in the Medicare Plus $1,000,000 contract for many years. We will update this term to now read “benefit period”. Staff recommends this change to a maximum of 120 days per benefit period as it has a limited impact on our members and it will make the Medicare Plus $1,000,000 plan consistent with Uniform Benefits. Deloitte states that the savings resulting from limiting the benefit to 120 days would be $.31 PMPM.

   Please note: Deloitte’s estimated cost of adding more complete preventive care covering physical exams and routine lab work would be between $6.00 to $6.50 PMPM in the first year, due to pent-up demand. At this time, staff is not recommending this coverage, however, it could bring a proposal back to the Board at a later date if there appears to be interest.

2. *Modify the Standard Plan's criteria to determine member qualification for gastric bypass surgery.*

   Annually, WPS reviews its medical policy on gastric bypass, or bariatric surgery, and makes recommendations to align it with standards of practice in the medical community, evidence-based medicine, and standards in the insurance community. For 2009 WPS has changed its medical policy to allow bariatric surgery for members with a body mass index (BMI) of 35 who can prove the existence of certain co-morbidities. Deloitte indicates that this change is becoming the industry standard. This BMI number is lower than the current requirement of a BMI of 40 for the surgery. This change also impacts the definition of 'morbid obesity' used in the contract. The new policy includes language that is more specific regarding what members are required to do or what types of medical documentation must be submitted to qualify for the surgery. WPS states that this policy change will likely result in an increase in utilization.

3. *Incorporate language into the overall contract to allow for the underwriting of prospective Wisconsin Public Employers (local government) groups down to a group size of one.*

   At its April 15, 2008, meeting the Board approved the underwriting process for small prospective local government employers with 50 employees or fewer. WPS provides this service and the contract must be updated to reflect this change. Currently, WPS charges $1,200 for underwriting each group of 51 or more. Small group underwriting follows a different process and the cost differs depending on the size of the group. The WPS fees are included in the PASA contract and appear in the grid below. Staff is also presenting Deloitte's fees in the grid. Deloitte's role is to verify WPS's calculation and establish the surcharge amount for the group. Deloitte's contract does not need to be updated to reflect this change.

Size of Group	WPS's Underwriting Fee	Deloitte's Underwriting Fee
1	$100	$100
2 to 9	$175	$200
10 to 25	$275	$300
26 to 35	$450	$450
36 to 50	$550	$600

   Staff is concerned that this cost, if passed on to employers in its entirety (as it is with large groups), would create a barrier preventing small employers from joining our group. Thus, staff recommends that the cost be absorbed by the current local participating groups, as this service will help to protect the pool from adverse selection. Staff considered recommending a nominal application processing fee of $50 to $100, depending upon group size, as this is consistent with ETF's approach in other programs. However, the fee presents administrative challenges so we do not recommend it at this time. If this policy presents a problem in the future, we will recommend reconsideration.

4. *Clarify the entire contract for the Alternative Care provision to allow a member's physician to have the ability to recommend the consideration of alternate care.*

   The contract states currently that "WPS may recommend" alternate care for the treatment of a member's illness or injury. Alternate care is considered when a member could receive a different course of treatment that is therapeutically equivalent to the current treatment, is not expected to jeopardize the member's health, and will probably cost less. Current contract language can be misinterpreted to mean that only WPS can propose the alternative. Our past practice has been to allow a member's physician to also submit recommendations for such alternate care. The plan administrator holds the final authority for approving or denying the request. Staff recommends modifying current language by adding language to allow a physician to suggest such treatment, while continuing to state that WPS has the final authority in determining if the alternative benefit is allowable or not.

5. *Clarify the entire contract's existing practice by adding a definition for Incidental Services and an exclusion for Indirect Services.*

   WPS recommends two clarifications to the contract by adding a definition and an exclusion to make the program easier to understand.

   a. WPS recommends defining the term "incidental" in the contract. Incidental services are those that occur at the same time as another service, but do not add significant time or effort so the charge for that secondary service is denied. Examples of incidental surgical services could be the removal of an appendix, gallbladder or hernia repair during an abdominal surgery for a reason not requiring these services.

   b. WPS recommends adding an exclusion for indirect services. These services include the creation of a laboratory's standards and the calibration of equipment. Currently these types of services are denied. WPS is recommending adding the exclusion for clarification of existing practice.

The grid also describes language being added to the schedule of benefits of the Standard Plans, to specifically state that the overall annual out-of-pocket amounts do not include benefits for the treatment of alcoholism, drug abuse, and nervous and mental disorders. This language is consistent with current practice and Wis. Stat. § 632.89, on which it is based.

Attachments

May 21, 2008

To: Arlene Larson
Manager, Self Insured Plans
Division of Insurance Services
Department of Employee Trust Funds

Arlene:

The following is a brief overview of proposed new benefit provisions that we suggest be added to your health plan effective January 1, 2009 as well as the reason to incorporate that language. Whenever the same provision is being changed on multiple pages in the contract and the text is repeated, we are only attaching one example of the change in text. However, the grid does include the reference to all affected pages.

Section and Page Number	**New Language for Health Benefit Plan**	**Reason for New Language**
Section I. Definitions, Page 7	Add definition for "incidental".	Within the Plan, this term is used; however, the term was never defined. Added definition for clarity.
Section I. Definitions, Page 8	Modify definition of "morbid obesity" to reference a BMI of 35.	WPS now determines morbid obesity for a participant with a BMI greater than 35 (previously this was 40) Medical literature supports gastric bypass for those who have a BMI of 35 with another risk factor such as hypertension, diabetes, etc.
Section III. Standard Plan Schedule of Benefits, Pages 27 & 28 Section VI. Wisconsin Public Employers Standard Plan, Pages 58, 61, 62 & 65	Add the following language to the annual out of pocket provision: This paragraph does not apply to BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS. BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall continue to be payable as specifically stated elsewhere in the PLAN.	In order to make the benefit more specific, language has been added to the Schedule of Benefits that once the out-of-pocket is met, the 100% coinsurance provision does not apply to treatment of alcoholism, drug abuse and nervous or mental disorders. This is consistent with current practice and the treatment of such co-pays in Wis. Stat. 632.89, on which it is based.
Section IV. Standard Plan Hospital, Professional and Other Services, pages 32, 33 &34 Section VI. Wisconsin Public Employers Standard Plan, pages 48, 49 & 50	With respect to bariatric surgery, modify requirements for such surgery to match current medically necessary criteria.	In order to align with current medical practice, WPS has expanded it's definition of morbid obesity and has modified the requirements that need to be met before a participant is eligible for bariatric surgery

Section VII. Medicare PLUS $1,000,000 Coverage, Page 76	Add the following additional benefit: Immunizations including, but not limited to, the following: diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; and varicella.	Addition of the immunization benefit to offset skilled nursing facility benefit change
Section VII. Medicare PLUS $1,000,000 Coverage, Pages 73 & 74	Add a maximum limit of 120-days per benefit period to the skilled nursing home benefit	By adding this limitation, this benefit now closely matches the skilled nursing home benefit currently in Uniform Benefits.
Section XII. Exclusions, Page 92	Add the following exclusion: Indirect services provided by health care providers for services such as, but are not limited to, creation of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing, setting up parameters for test results; and reviewing quality assurance data.	Additional language will clarify those services which should not be billed because they are considered as part of the provider's administration, not as an actual service provided.
Section XIV. General Conditions, Page 95	Modify alternate treatment language to allow not only WPS' recommendation for alternate treatment but also a participant's physician's recommendation	To further clarify the contract, this language will allow a physician to recommend alternate treatment.

If you have any questions, please do not hesitate to contact me.

Cheryl Forrer, Manager Contract Development

STATE OF WISCONSIN

GROUP INSURANCE BOARD

HEALTH BENEFIT PLAN

TABLE OF CONTENTS

I. DEFINITIONS

In the event of a conflict between this CONTRACT and any applicable federal or State statute, administrative rule or regulation, GUIDELINES or RFP, the statute, rule or regulation will control.

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

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

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

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

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

ANNUITANT means the following:

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

b. any retired EMPLOYEE of a participating EMPLOYER who: (1) is receiving an immediate annuity under the Wisconsin Retirement System; or (2) is a person with 20 years of creditable service who is eligible for an immediate annuity but defers application; or (3) is a person receiving an annuity through a program administered by the DEPARTMENT under §. 40.19 (4) (a); or (4) is a person receiving a benefit under Wis. Stats § 40.65. For those local Employees who are over age 65, SMP does not apply.

BENEFITS mean payments for HOSPITAL SERVICES, PROFESSIONAL SERVICES and OTHER SERVICES under the HEALTH BENEFIT PLAN. For purposes of the lifetime maximum benefit limit, BENEFITS shall include all payments made under the prescription legend drug program.

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

BOARD means the Group Insurance Board.

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

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

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

CHARGE means an amount for a HEALTH CARE SERVICE provided by a HEALTH CARE PROVIDER that is reasonable, as determined by WPS, when taking into consideration, among other factors

determined by WPS, amounts charged by HEALTH CARE PROVIDERS for similar HEALTH CARE SERVICES 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 HEALTH CARE SERVICES. The term "area" means a county or other geographical area which WPS determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. In some cases the amount WPS determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the HEALTH CARE SERVICE. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

Benefits for charges for covered bilateral and multiple surgical procedures and for a covered surgical procedure that requires a surgical assistant to be present are determined by WPS only as described in Section IV. C. 1. b., c., d. and e. and Section VI. B. 3. a. (2), (3), (4) and (5).

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

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

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

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

CONGENITAL means a condition, which exists at birth .

CONTINUANT means any SUBSCRIBER enrolled under the federal or state continuation provisions as described in the HEALTH BENEFIT PLAN.

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

CUSTODIAL CARE means that type of care, which is designed essentially to assist a person to meet or maintain activities of daily living. It does not entail or require the continuing attention of trained medical personnel such as registered nurses and licensed practical nurses. CUSTODIAL CARE includes those HEALTH CARE SERVICES which constitute personal care such as help in walking and getting in and out of bed; assistance in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision of medication which usually can be self-administered. Care may also be custodial even though such care involves the use of technical medical skills. Notwithstanding the above, custodial care is also provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a PHYSICIAN, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

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

DEPARTMENT means the Department of Employee Trust Funds.

DEPENDENT means the SUBSCRIBER'S:

a. Sspouse;

b. **U** of the SUBSCRIBER and his or her unmarried child;ren (

c. Lincluding legal wards who becomes a legal wards of the SUBSCRIBER prior to age 19, but not a temporary wards;

d. A, of the SUBSCRIBER prior to age 19, adopted children when or children placed in the custody of the parent for adoption as provided by for in Wis. Stats. § 632.896;

e. S, and stepchild;

f. Grandchild if the parent is a dependent child. The dependent grandchild will be covered until the end of the month in which the dependent child turns age 18.

A ren), who are dependent child must be dependent on the SUBSCRIBER (or the other parent) for at least 50% of the child's ir support and maintenance as demonstrated on and meet the support tests as a DEPENDENT for federal income tax purposes, (whether or not the child is claimed.)

A child, and children of those dependent children until the end of the month in which the dependent child turns age 18. Adoptive children become DEPENDENTS when placed in the custody of the parent as provided by Wis. Stat. § 632.896. Children born outside of marriage become a DEPENDENTS 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 and Family Services or equivalent if the birth was outside the State of Wisconsin. The EFFECTIVE DATE of coverage will be the date of birth if a statement of paternity or a court order is filed within 60 days of the birth.

A spouse and a stepchildren cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment. Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards. Other children cease to be DEPENDENTS at the end of the CALENDAR YEAR in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

a. A cChildren age 19 or over who is a are full-time students, if otherwise eligible (that is, continues to be a DEPENDENT for support and maintenance and is not married), cease to be a DEPENDENTS: (1) at the end of the CALENDAR YEAR in which the child y ceases to be a full-time students or in which the child y turns age 25, whichever occurs first; or (2) at the end of the month in which the childy cease to be dependent for support and maintenance or marriesy, whichever occurs first.

b. Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, the term "school"this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools and similar on-line programs, intersession courses (for example, courses during winter break), night schools and student commitments after the semester ends, such as student teaching. As required by Wis. Stat. § 632.895 (15), eligibility will continue up to one year when the DEPENDENT ceases to be a full-time student due to a medically necessary leave of absence.

b~~c~~**.** A dependent ~~If otherwise eligible~~ child~~ren~~ who is~~are, or become,~~ incapable of self-support ~~on account~~because of a physical or mental disability that ~~, which~~ can be expected to be of long-continued or indefinite duration of at least one year ~~or longer, they continue to be or resume their status of~~is an eligible DEPENDENT~~S~~, regardless of age ~~or student status~~, so long as the child~~y~~ remains so disabled if he or she is otherwise eligible (that is, the child meets the support tests as a DEPENDENT for federal income tax purposes and is not married). ~~The child must have been previously covered as an eligible DEPENDENT under this program in order to resume coverage.~~ The PLAN will monitor mental or physical disability at least annually, ~~but will only~~ terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled, and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the PLAN determination.

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

~~**e.**~~ Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of eligibility, not on the date of notification to the PLAN and/or pharmacy benefit manager.~~lan.~~

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

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

b. generally not useful to a person in the absence of an ILLNESS or INJURY;

c. appropriate for use in the PARTICIPANT'S home; and

d. prescribed by a PHYSICIAN.

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

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

EMERGENCY MEDICAL CARE means HEALTH CARE SERVICES directly provided by a HEALTH CARE PROVIDER to treat a PARTICIPANT'S medical emergency. A medical emergency is a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson to reasonably conclude that a lack of medical attention will likely result in any of the following:

a. Serious jeopardy to the PARTICIPANT'S health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.

b. Serious impairment to the PARTICIPANT'S bodily functions.

c. Serious dysfunction of one or more of the PARTICIPANT'S body organs or parts.

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

EMPLOYER means the employing State agency or participating local government.

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

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

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

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

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

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

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

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

c. is the subject of either: (1) a written investigational or research protocol; or (2) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (3) an ongoing phase I, II or III clinical trial, except as required by law; or (4) an ongoing review by an Institutional Review Board (IRB); or

d. doesn't have either: (1) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (2) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning such treatment, service or supply and reflecting its recognition and reproducibility by non-affiliated sources we determine to be authoritative.

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

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

b. whether the HEALTH CARE SERVICE 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 HEALTH CARE SERVICE;

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

e. whether the HEALTH CARE SERVICE is MEDICALLY NECESSARY;

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

EXTENDED CARE FACILITY means a convalescent or chronic disease facility, whether operated independently or as a part of a GENERAL HOSPITAL which is accredited by the Joint Commission on Accreditation of Hospitals, or is recognized as an EXTENDED CARE FACILITY under MEDICARE or which is a nursing home as defined in Wis. Stats. § 50.01 (3). The term excludes facilities providing HEALTH CARE SERVICES primarily for custodial or domiciliary care or for the care of drug addiction or alcoholism.

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

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

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

a. a convalescent or EXTENDED CARE FACILITY unit within or affiliated with the HOSPITAL;

b. a clinic;

c. a nursing, rest or convalescent home, or EXTENDED CARE FACILITY;

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

e. a sub-acute care center, health resort, spa or sanitarium.

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

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

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

HEALTH BENEFIT PLAN/PLAN means the part of this CONTRACT that provides BENEFITS for HEALTH CARE SERVICES, as described in Sections I. through XIV.

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

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

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

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

HOSPITAL means a GENERAL HOSPITAL and a SPECIALTY HOSPITAL.

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

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

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

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

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

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

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

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

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

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

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

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

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

MAINTENANCE THERAPY means ongoing therapy delivered after the acute phase of an illness has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes MAINTENANCE THERAPY is made by WPS after reviewing an individual's case history or TREATMENT plan submitted by a provider.

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

MEDICALLY NECESSARY means a HEALTH CARE SERVICE directly provided to a PARTICIPANT by a HOSPITAL, PHYSICIAN or other HEALTH CARE PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by WPS:

a. consistent with the symptom(s) or diagnosis and TREATMENT of the PARTICIPANT'S ILLNESS or INJURY;

b. appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY;

c. not solely for the convenience of the PARTICIPANT, PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER;

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

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

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

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

a. primarily used to treat an ILLNESS or INJURY;

b. generally not useful to a person in the absence of an ILLNESS or INJURY;

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

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

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

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

MORBID OBESITY/MORBIDLY OBESE means when a PARTICIPANT has a five year history~~'S~~ of a Body Mass Index (BMI) ~~is~~ greater than 35~~40~~. Body Mass Index is defined as the PARTICIPANT'S weight in kilograms divided by the square of their height in meters. A PHYSICIAN must define MORBID OBESITY utilizing the method stated in this definition.

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

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

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

OTHER COVERAGE means any group or franchise contract, policy, plan or program of prepaid service care or insurance arranged through any employer, trustee, union or association including, but not limited to, disability, health and accident or sickness care coverage, or the medical payments provisions of an

automobile insurance policy, any or all of which would provide BENEFITS for medical care of any nature either on a service or expense incurred basis if this CONTRACT was not in effect.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PREFERRED HEALTH CARE PROVIDER means a HEALTH CARE PROVIDER, other than a PREFERRED PHYSICIAN or a PREFERRED HOSPITAL, who has entered into a written preferred provider agreement with the HEALTH CARE PROVIDER network shown on a PARTICIPANT'S PLAN Identification Card. The Preferred Provider Directory is available on the Internet at www.wpsic.com/state or by request from WPS. Please note that PREFERRED PROVIDERS may change periodically. While the on-line Preferred Provider Directory is updated frequently, the presence of a provider's name in the listing does not guarantee or mean that that specific provider participates in that network at the time that a PARTICIPANT receives any service from that provider. However, HEALTH CARE PROVIDERS who

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

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

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

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

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

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

PROFESSIONAL SERVICES means HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PHYSICIAN of the PARTICIPANT'S choice to treat his/her ILLNESS or INJURY. Such HEALTH CARE SERVICES include HEALTH CARE SERVICES provided by a certified registered nurse anesthetist, registered or licensed practical nurse, laboratory/x-ray technician and physician assistant provided such person is lawfully employed by the supervising PHYSICIAN or the facility where the HEALTH CARE SERVICE is provided, and he/ she provides an integral part of the supervising PHYSICIAN'S PROFESSIONAL SERVICES while the PHYSICIAN is present in the facility where the HEALTH CARE SERVICE is provided. With respect to such HEALTH CARE SERVICES provided by a registered nurse or licensed practical nurse, laboratory/x-ray technician and physician assistant, such HEALTH CARE SERVICES must be billed by the supervising PHYSICIAN or the facility where the HEALTH CARE SERVICE is provided.

ROOM ACCOMMODATIONS means bed and room including nursery care, meals and dietary SERVICES and general nursing SERVICES provided to an INPATIENT.

SELF-ADMINISTERED INJECTABLE means an injectable that is administered subcutaneously and can be safely self-administered by the PARTICIPANT and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intraarterial) injections or any drug administered through infusion.

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

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

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

SMP means State Maintenance Plan.

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

STANDARD PLAN means this CONTRACT excluding SMP, Wisconsin Public Employers and Medicare Plus $1,000,000 coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WISCONSIN PUBLIC EMPLOYERS means STANDARD and SMP plan BENEFITS provided to participating local government EMPLOYERS pursuant to Wis. Stats. § 40.51 (7).

II. ENROLLMENT AND ELIGIBILITY

Any contractual provisions found in Article 3. of the "Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Program and Uniform Benefits" for the Wisconsin Public Employers is hereby incorporated by reference.

A. ENROLLMENT DATA

EMPLOYEES and ANNUITANTS are PARTICIPANTS if they have filed with the EMPLOYER or DEPARTMENT, if applicable, an enrollment application in the form prescribed by the DEPARTMENT, and are eligible in accordance with this CONTRACT, the law, administrative rules and regulations of the DEPARTMENT.

Identification cards for such PARTICIPANTS will be generated and issued upon receipt of the carrier-advanced application.

B. SELECTION OF COVERAGE

1. If coverage is not elected under this section, it shall be subject to the deferred coverage provision of Subsection I, below.

Except as otherwise provided in this section, coverage shall be effective on the first day of the month, which begins on, or after the date the application is received by the EMPLOYER. No application for coverage may be rescinded on or after the effective date of coverage.

2. **a.** An EMPLOYEE shall be covered under the PLAN if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, to be effective on the first day of the month following receipt of the application by the EMPLOYER, or prior to becoming eligible for EMPLOYER contributions to be effective upon becoming eligible for EMPLOYER contribution. In accordance with Wis. Stats. § 40.51 (2), an EMPLOYEE who enrolls for single coverage within 30 days of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for EMPLOYER contribution toward premium. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements. However, when the EMPLOYEE terminates employment prior to the EFFECTIVE DATE of coverage, the application is void and any premiums paid or deducted will be refunded.

b. Notwithstanding paragraph 2. a. above, an EMPLOYEE who is not covered under the PLAN but who is eligible for an EMPLOYER contribution under Wis. Stat. § 40.05 (4) (ag) 1 may elect coverage prior to becoming eligible for an EMPLOYER contribution under Wis. Stat § 40.05 (4) (ag) 2 to be effective upon the date of the increase in the EMPLOYER contribution. An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following receipt of the application by the EMPLOYER.

3. **a.** An EMPLOYEE eligible and enrolled for SINGLE COVERAGE only may change to FAMILY COVERAGE effective on the date of change to family status, including transfer of custody of eligible dependents, if an application is received by the EMPLOYER within 30 days after the date of the change to family status. The difference in PREMIUM between SINGLE COVERAGE and FAMILY COVERAGE for that month shall be due only if the change is effective before the 16th day of the month. ANNUITANTS shall submit the application to the DEPARTMENT.

b. Notwithstanding paragraph 3. a. , above, the birth or adoption of a child to a SUBSCRIBER under SINGLE COVERAGE, who was previously eligible for FAMILY COVERAGE, will allow the SUBSCRIBER to change to FAMILY COVERAGE if an application is received by the EMPLOYER within 60 days of the birth, adoption, or placement for adoption.

4. In addition to any enrollment period required under Wis. Stat. § 40.05 (4g), an EMPLOYEE enrolled for coverage at the time of being called into active military service whose coverage lapses shall be entitled to again enroll upon resumption of eligible employment with the same EMPLOYER subject to the following:

a. Employment is resumed within 180 days after release from active military service, and

b. The application for coverage is received by the EMPLOYER within 30 days after return to employment.

c. An EMPLOYEE who is enrolled for SINGLE COVERAGE and becomes eligible for FAMILY COVERAGE between the time of being called into active military service and return to employment may elect FAMILY COVERAGE within 30 days upon re-employment without penalty.

d. Coverage is effective upon the date of re-employment. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

5. If a person is erroneously omitted from participation under the Wisconsin Retirement System and the omission is corrected retroactively, including payment of all Wisconsin Retirement System required contributions for the retroactive period, the DEPARTMENT is empowered to fix a deadline for submitting an application for prospective group health care coverage if the person would have been eligible for the coverage had the error never occurred.

6. In the event that an employer erroneously continues to pay the PREMIUM for an EMPLOYEE who terminates employment, refunds of such PREMIUMS shall be limited to no more than two months of PREMIUMS paid.

7. E~~If a person is erroneously enrolled and participating under the Wisconsin Retirement system and the enrollment is corrected retroactively, e~~xcept in cases of fraud, unreported death, misrepresentation, resolution of BOARD appeal, or when required by MEDICARE, retrospective adjustment to premium or claims for coverage not validly in force shall not be made prior to January 1 of the previous calendar year. No retroactive premium refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation. In situations where coverage is validly in force, the employer has not paid PREMIUM and the EMPLOYEE does not have a required contribution, retroactive PREMIUM will be made for the entire period of coverage regardless of discovery date. WPS is responsible for resolving discrepancies for all Medicare data match inquiries.

8. In the event that an EMPLOYER determinates an effective date under Wis. Stat. § 40.51 (2) based on information obtained from the DEPARTMENT available at the time the application is filed, such application shall not be invalidated solely as a result of an administrative error in determining the proper EFFECTIVE DATE of EMPLOYER contribution. No such error will result in providing coverage for which the EMPLOYEE would otherwise not be entitled.

9. As required by state and federal law, a SUBSCRIBER enrolled in SINGLE COVERAGE although eligible for FAMILY COVERAGE, or an EMPLOYEE who deferred the selection of coverage, has a special enrollment opportunity to add eligible children as required by a National Medical Support Notice.

10. **a.** An eligible EMPLOYEE may defer the selection of coverage under this Section II if he/she is covered under another health insurance plan, or under medical assistance (Medicaid), or as a member of the US Armed Forces, or as a citizen of a country with national health care coverage comparable to the STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE loses eligibility for that OTHER COVERAGE or the employer's contribution towards the OTHER COVERAGE ceases, he/she may elect coverage under any plan by filing an application with the EMPLOYER within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. An EMPLOYEE enrolled for SINGLE COVERAGE, though eligible for FAMILY COVERAGE, may change to FAMILY COVERAGE if any eligible DEPENDENTS covered under another plan lose eligibility for that coverage or the EMPLOYER'S contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage.

b. An EMPLOYEE who deferred coverage may enroll for family coverage if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption, or marriage provided he or she submits an application for family coverage within 60 days of that event.

c. Coverage under this provision shall be effective on the date of termination of the prior plan or the date described in b. above. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

11. In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary PHYSICIAN or clinic that ~~who~~ is not available in the plan selected, WPS shall immediately notify the EMPLOYER. T~~t~~he SUBSCRIBER shall be allowed to correct the plan selected to one which ~~that~~ has that PHYSICIAN or clinic available, upon notice to the EMPLOYER that the error occurred. The application shall be effective the later of first of the month following receipt of the application or the EFFECTIVE DATE of the original application. WPS may not simply reassign a primary PHYSICIAN or clinic.

12. PARTICIPANTS who have escrowed their sick leave or have their sick leave preserved as provided for in statute may re-enroll in any PLAN without underwriting restrictions as follows:

a. Coverage for those who have escrowed under Wis. Stat. § 40.05 (4) (b) and (be) may enroll during the dual choice enrollment period and effective of the first day of the month selected by the PARTICIPANT of the following year as provided in section 3.4 (1).

b. For the PARTICIPANTS defined in Wis. Stat. § 40.02 (25) (b) (6e) and (6g) whose sick leave has been preserved under Wis. Stat. § 40.05 (4) (bc) , coverage will begin on the first of the month following the DEPARTMENT'S receipt of the health insurance application, unless otherwise specified on the application.

c. PARTICIPANTS losing eligibility for other coverage or the employer's contribution towards the OTHER COVERAGE ceases, may elect coverage under any PLAN by filing an application with the DEPARTMENT within 30 days of the loss of eligibility. A PARTICIPANT enrolled for SINGLE COVERAGE, though eligible for FAMILY COVERAGE, may change to FAMILY COVERAGE if any eligible DEPENDENT'S are covered under the other plan and lose eligibility for that coverage or the employer's PREMIUM contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage. Coverage shall be effective on the date of

termination of the prior plan or the date of the event. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

13. Eligible retired EMPLOYEES or former EMPLOYEES pursuant to 40.51 (16) may enroll in any plan effective on the first day of the seventh month following receipt of application by the DEPARTMENT.

C. DUAL-CHOICE ENROLLMENT PERIODS

1. The BOARD shall establish enrollment periods that shall permit eligible and currently covered EMPLOYEES and ANNUITANTS to transfer coverage to any health care coverage plan offered by the BOARD pursuant to Wis. Stats. § 40.51. Unless otherwise provided by the BOARD, the dual-choice enrollment period shall be held once annually in the fall of each year with coverage effective the following January 1.

2. If a SUBSCRIBER has not received a dual-choice enrollment opportunity as determined by the DEPARTMENT, an enrollment opportunity may be offered prospectively.

3. An EMPLOYEE who returns from leave of absence during which coverage lapsed and which encompassed the entire previous dual-choice enrollment period will be allowed a dual-choice enrollment provided an application is filed during the 30 day period which begins on the date the EMPLOYEE returns from leave of absence.

4. An EMPLOYEE, ~~or an~~ ANNUITANT, or CONTINUANT may also change plans if the SUBSCRIBER moves from his/ her residence across county lines for a minimum of three months. A move from a medical facility to another facility by the SUBSCRIBER is not considered a residential move. An application must be filed during the 30-day period, which begins on the date the SUBSCRIBER moves.

5. As required by federal law, an EMPLOYEE, ANNUITANT, or CONTINUANT may change plans if a claim is incurred by a PARTICIPANT that would meet or exceed the lifetime maximum BENEFITS. An application must be filed during the 30-day period after a claim is denied due to the operation of a lifetime limit on all BENEFITS with coverage effective on the first day of the month on or following receipt of the application.

6~~5~~. A SUBSCRIBER under 3., ~~and~~ 4. and 5., above, who does not file an application to change plans within this 30-day enrollment period may change only to the STANDARD PLAN , and shall be subject to the waiting period for pre-existing conditions contained in the STANDARD PLAN CONTRACT. Coverage shall be effective the first day of the calendar month that begins on or after the date the application is received by the EMPLOYER.

7~~6~~. A SUBSCRIBER whose health plan is not offered in the next year as a result of the PLAN'S decision to cease participation in the BOARD'S program, and who does not file an application to change plans during the dual-choice enrollment period, may enroll only in the STANDARD PLAN, however, the waiting period for preexisting conditions clause contained in the STANDARD PLAN will be waived. Coverage shall be continuous, and will be effective under the STANDARD PLAN as of January 1, of the year following the plan's withdrawal. There cannot be a lapse in coverage. In no case can coverage be reinstated after June 30 of the year following the plan's withdrawal from participation. If the discovery of the failure to make this dual-choice occurs after June 30 of the year following the plan's withdrawal from participation, coverage is terminated effective January 1 and re-enrollment may only be in the STANDARD PLAN, however, the waiting period for preexisting conditions contained in the STANDARD PLAN CONTRACT will be enforced.

8~~7~~. Applications from ANNUITANTS and CONTINUANTS changing plans during the Dual Choice enrollment period must be received by the DEPARTMENT postmarked no later than the last day of the Dual Choice enrollment period, unless otherwise authorized by the DEPARTMENT.

9. As required by federal law, an EMPLOYEE, ANNUITANT, or CONTINUANT who is adding one or more DEPENDENTS to the PLAN due to marriage, birth, adoption, placement for adoption, loss of other coverage, or loss of EMPLOYER contribution for the other coverage may change plans after the event if an application is submitted within 30 days of the event. Coverage will be effective the first day of the calendar month, which begins on or after the date the EMPLOYER receives the application.

D. INITIAL PREMIUMS

When coverage becomes effective, multiple PREMIUM payments may be required initially to make PREMIUM payments current.

E. CONSTRUCTIVE WAIVER OF COVERAGE

Any enrolled EMPLOYEE in active pay status for whom the EMPLOYEE portion of PREMIUMS has not been deducted from salary by the EMPLOYER for a period of 12 consecutive months, shall be deemed to have waived coverage. Coverage then may be obtained only under the deferred coverage provisions of Subsection I., below.

F. BENEFITS NON-TRANSFERABLE

No person other than a PARTICIPANT, as recorded in the office of the PLAN, is entitled to BENEFITS under this CONTRACT. The SUBSCRIBER or any of his or her DEPENDENTS who assigns or transfers their rights under the CONTRACT, aids any other person in obtaining BENEFITS or knowingly presents or causes to be presented a false or fraudulent claim shall be guilty of a Class A misdemeanor as prescribed under Wis. Stat. § 943.395, and subject to the penalties set forth under Wis. Stats. § 939.51 (3) (a).

G. NON-DUPLICATION OF BENFEITS

The administration of BENEFITS provisions under the CONTRACT must conform to Wis. Admin. Code. § 3.40.

H. REHIRED OR TRANSFERRED EMPLOYEE COVERAGE

1. Covered STATE EMPLOYEES.

a. Any covered EMPLOYEE who terminates employment with the State and is re-employed by the State in a position eligible for health coverage under the PLAN within 30 days or who terminates employment for a period of more than 30 days that does not comply with Wis. Adm. Code § 10.08 (2) and (3) shall be deemed to have been on leave of absence for that time and is limited to previous coverage.

b. If a covered EMPLOYEE transfers from one State agency to another, an application must be filed within 30 days to maintain continuous coverage. If no application is filed within the 30-day enrollment period, continuous coverage may be reinstated by filing an application and paying back PREMIUM. The constructive waiver of coverage under Section II. E. will apply.

2. COVERED EMPLOYEE of an EMPLOYER Participating under Wis. Stats. § 40.51.

Any COVERED EMPLOYEE who terminates employment with an EMPLOYER participating under Wis. Stats. § 40.51, and is re-employed by the same EMPLOYER within 30 days in a position eligible for health coverage under the PLAN shall be deemed to have been on leave of absence for that time and is limited to previous coverage.

I. DEFERRED COVERAGE

1. Any EMPLOYEE actively employed with the State or an EMPLOYER participating under Wis. Stats. § 40.51, who does not elect coverage during the enrollment period provided under Section II. B. or II. K. 3, or who constructively waives coverage under Section II. E., or who subsequently cancels coverage elected under Sections II. B. or II. C. may be covered under the PLAN only under the STANDARD PLAN, subject to any eligibility criteria and waiting period for pre-existing conditions contained in the STANDARD PLAN CONTRACT. Coverage shall be effective the first day of the calendar month that begins on or after the date the application is received by the EMPLOYER.

2. An EMPLOYEE or ANNUITANT enrolled for SINGLE COVERAGE, though eligible for FAMILY COVERAGE, and who subsequently elects FAMILY COVERAGE after the initial eligibility period specified in Section II. B. 3., shall be eligible for FAMILY COVERAGE under the STANDARD PLAN. DEPENDENTS shall be subject to any waiting period for pre-existing conditions contained in the STANDARD PLAN CONTRACT.

3. This section does not preclude a covered EMPLOYEE or ANNUITANT from changing to an alternate health care coverage plan during a dual-choice enrollment period offered under Section II. C., above.

4. A retired EMPLOYEE of the State who is receiving a retirement annuity or has received a lump sum payment under Wis. Stats. § 40.25 (1), or an EMPLOYEE of the State who terminates creditable service after attaining 20 years of creditable service, remains a PARTICIPANT in the Wisconsin Retirement System and is not eligible for an immediate annuity may become insured effective on the first day of the seventh month following receipt of the application by the DEPARTMENT.

J. COVERAGE OF SPOUSE

If both spouses are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect SINGLE COVERAGE, but if one spouse elects FAMILY COVERAGE, the other eligible spouse may be covered as a DEPENDENT but may not have any OTHER COVERAGE. Two SINGLE COVERAGES may be combined to one FAMLY COVERAGE, FAMILY COVERAGE may be converted to two SINGLE COVERAGES, or the FAMLY COVERAGE may be changed from one spouse to the other without penalty effective the first day of the calendar month which begins on or after the date the DEPARTMENT or EMPLOYER receives the application, or at a later date as specified on the application. If the spouses have coverage with different HEALTH PLANS at the time of marriage or when two single contracts are combined to one family contract, they may elect FAMILY COVERAGE with either PLAN. Should the spouses become divorced while carrying FAMILY COVERAGE, the divorced spouse may elect coverage without lapse if the EMPLOYER received the application within 30 days of the divorce.

Wisconsin Public Employers Only: An employer may, at its option, allow both spouses to enroll for family coverage or one for single and one for family and coverage can be changed from one spouse to the other without restrictions.

Upon an EMPLOYER'S request, the DEPARTMENT may approve, at its discretion, a special enrollment opportunity for affected EMPLOYEES due to a change in policy for coverage of spouses.

K. COVERAGE DURING AN UNPAID LEAVE OF ABSENCE

1. A covered EMPLOYEE may continue coverage during an EMPLOYER approved leave of absence or LAYOFF for up to 36 months. Coverage may be continued beyond 36 months if the approved leave is a union service leave as provided for under Wis. Stats. § 40.02 (56) and 40.03 (6) (g). A return from a leave of absence under Wis. Stats. § 40.02 (40) is deemed to be the first day the EMPLOYEE returns to work if the EMPLOYEE resumes active performance of duty for 30 consecutive days for at least 50% of the

EMPLOYEE'S normal work time. If the EMPLOYEE does not complete 30 days of duty, coverage as an active EMPLOYEE shall not be resumed.

2. **a.** For State Employees Only, the EMPLOYER contribution toward PREMIUM continues for ~~After~~ the first three months of the LAYOFF or leave of absence for which the PREMIUMS have not been deducted~~, the COVERED~~. Thereafter, the COVERED EMPLOYEE is responsible for payment of the full PREMIUM that must be paid in advance.

b. For Wisconsin Public Employers Only, during any period of LAYOFF or leave of absence, the COVERED EMPLOYEE is responsible for payment of the full PREMIUM, unless the EMPLOYER continues contribution toward premium, that must be paid in advance.

E~~, and e~~ach payment must be received by the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS had previously been paid. Retroactive employer refunds resulting from termination for non-payment of PREMIUM by the EMPLOYEE is not allowed.

3. Any covered EMPLOYEE for whom coverage lapses or who allows FAMILY COVERAGE to lapse during the leave of absence but continues SINGLE COVERAGE as a result of nonpayment of PREMIUM may reinstate coverage by filing an application with the EMPLOYER within 30 days of return from leave to be effective the first day of the month on or after the date the EMPLOYER receives the application. If such an EMPLOYEE was on a leave under the Family Medical Leave Act (FMLA), coverage is effective upon the date of re-employment in accordance with federal law. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

4. For the purpose of this provision and in accordance with Wis. Stat. § 40.05 (4g), an eligible EMPLOYEE includes National Guard and Military Reserve personnel on an unpaid military leave of absence for active duty for reasons other than for training. The EMPLOYEE must be receiving State contributions for health insurance on the date he or she is activated for duty. The thirty-six month limitation for continuing coverage, described in 1. above, does not apply.

The EMPLOYEE may elect to:

a. Continue health coverage and establish prepayment of PREMIUMS while on active duty; or

b. Within 60 days of being activated for coverage, let his or her coverage lapse for non-payment of PREMIUM after being activated for duty and reinstate coverage while on leave by filing a health application (ET-2301); or

c. Allow his or her coverage to lapse and reapply for coverage within 30 days of return to employment, provided employment resumes within 90 days after release from active duty.

L COVERAGE DURING APPEAL FROM REMOVAL OR DISCHARGE

1. A covered EMPLOYEE who has exercised a statutory or contractual right of appeal from removal or discharge from his or her position, or who within 30 days of discharge becomes a party to arbitration or to legal proceedings to obtain judicial review of the legality of the discharge, may continue to be covered under the PLAN from the date of the contested discharge until a final decision has been reached. Within 30 days of the date of discharge, the EMPLOYEE must submit to the EMPLOYER the initial PREMIUM payment to keep the coverage in force. Additional payments may be made until a determination has been reached, but shall be submitted to the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS were previously paid.

2. If the final decision is adverse to the EMPLOYEE, the date of termination of employment shall, for purposes of health care coverage, be the end of the month in which the decision becomes final by expiration without appeal of the time within which an appeal might have been perfected, or by final affirmation on appeal.

3. The PREMIUMS referred to in this section shall be the gross amount paid to the plan for the particular coverage, including the pharmacy and administration fees. The ~~and the~~ EMPLOYEE shall be required to pay any amounts normally considered the EMPLOYER contribution. If the right of the EMPLOYEE to the position is sustained, the EMPLOYER shall refund to the EMPLOYEE any amounts paid in excess of the normal EMPLOYEE contribution.

M. CONTINUED COVERAGE OF SURVIVING DEPENDENTS

1. As required by Wis. Adm. Code § 40.01, t~~T~~he surviving covered DEPENDENT of a covered EMPLOYEE or ANNUITANT shall continue coverage, either SINGLE COVERAGE or FAMILY COVERAGE, if the DEPARTMENT receives an application for coverage from the surviving DEPENDENT within 90 days after the death of the covered EMPLOYEE or ANNUITANT or 30 days of the date the DEPARTMENT notifies the DEPENDENT of the right to continue, whichever is later. A DEPENDENT that regains eligibility and was previously covered under a CONTRACT of a deceased EMPLOYEE or ANNUITANT will be eligible for coverage until such time that they are no longer eligible.

2. Coverage under this section shall be effective on the first day of the calendar month following the date of death of the covered EMPLOYEE or ANNUITANT and shall remain in effect until such time as the DEPENDENT coverage would normally cease.

3. PREMIUMS shall be paid:

a. From accumulated leave credits until exhausted; then

b. By deductions from an annuity that the surviving DEPENDENT is receiving from the Wisconsin Retirement System. If the annuity is insufficient to allow PREMIUM deductions, then

c. Directly to the PLAN.

4. When such DEPENDENT continues coverage, he or she may change plans if such DEPENDENT lives in a county in which the DEPENDENT'S current plan has no providers.

N. COVERAGE OF EMPLOYEES AFTER RETIREMENT

1. Coverage for a covered EMPLOYEE shall be continued if the EMPLOYEE:

a. Retires on an immediate annuity as defined under Wis. Stats. § 40.02 (38).

b. EMPLOYEES who receive a disability annuity and remain continuously covered under the group shall be considered to have met the requirements for an immediate annuity for health coverage purposes. If the disability annuity terminates and the PARTICIPANT continues to meet the definition of eligible EMPLOYEE under Wis. Stat. § 40.02 (25), the individual is eligible to continue using accumulated leave credits until exhausted under Wis. Stat. § 40.05 (4) (b).

c. Terminates employment after attaining 20 years of creditable service. An application for continued coverage must be filed with the DEPARTMENT within 90 days of the termination of employment if the terminated EMPLOYEE is not eligible for an immediate annuity.

d. Receives a long-term disability benefit as provided under Wis. Adm. Code ' ETF 50.40.

2. Coverage for a person otherwise eligible, who is entitled to:

a. and applies for an immediate annuity under Wis. Stat. § 40.02 (38), may be reinstated even if during any period preceding retirement, coverage has not been in effect while no earnings were received, or coverage has been continued under COBRA continuation through the State's health program. An application for health coverage must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S notification of eligibility for health insurance ~~approval notice~~. Coverage shall be effective the first day of the calendar month, which occurs on or after the date the application for health coverage has been received.

b. and applies for an LTDI benefit under Wis. Adm. Code ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65, may be reinstated even if, during the period proceeding the benefit approval, no coverage was in effect while no earnings were received, or coverage has been continued under COBRA continuation through the State's health program. An application for health coverage must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S notification of eligibility for health insurance ~~approval notice~~. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health coverage has been received.

3. The DEPARTMENT may authorize PREMIUM payments to be made directly to the PLAN where circumstances require such. Failure to make required PREMIUM payments by the due dates established by the PLAN and approved by the DEPARTMENT shall cause the health care coverage to be cancelled.

O COVERAGE OF ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE

1. Each covered ANNUITANT, their DEPENDENTS or surviving DEPENDENTS or CONTINUANT who become insured under federal plans for HOSPITAL and medical care for the aged (MEDICARE) may continue to be covered under the PLAN, but at reduced PREMIUM rates as specified by the BOARD.

2. The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the MEDICARE hospital and medical insurance BENEFITS (Parts A and B) become effective as the primary payor.

3. Except in cases for fraud which shall be subject to subsection Q. (5), coverage for any PARTICIPANT enrolled in Medicare coordinated coverage who does not enroll in MEDICARE Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage ~~carrier~~ shall be limited in accordance with Uniform Benefits IV. A. 12. b. In such case, the PARTICIPANT must enroll in MEDICARE Part B at the next available opportunity. In the event that a PARTICIPANT is enrolled in regular coverage, ~~and~~ the DEPARTMENT will direct the PLAN to refund any PREMIUM paid in excess of the MEDICARE reduced premium for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV., A. 12., b. In such cases, the PLAN should make claims adjustments prospectively.

4. Enrollment under the federal plans for HOSPITAL and medical care for the aged (MEDICARE) by EMPLOYEES and ANNUITANTS who are eligible for those programs is waived if the EMPLOYEE remains covered as an active EMPLOYEE of the State. Enrollment in MEDICARE Part B is required for the EMPLOYEE or DEPENDENTS at the first MEDICARE enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active EMPLOYEE'S group health insurance policy with another EMPLOYER and that policy is the primary payor for Part A and Part B charges, the ANNUITANT or the ANNUITANT'S spouse covered under that policy may also defer enrollment in MEDICARE Part B (to the extent allowed by federal law) under this provision and shall pay the MEDICARE rates for coverage under this

program. This policy will pay as if the ANNUITANT and spouse were covered under the MEDICARE+$1,000,000 policy.

5. Enrollment under the federal plans for hospital care for the aged (MEDICARE) by EMPLOYEES, ANNUITANTS, CONTINUANTS and their DEPENDENTS who are eligible for those programs is waived if the covered EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is required to pay a premium to enroll in the hospital portion of MEDICARE (Part A). However, if Part A is not elected, the reduced PREMIUM rate is not available.

6. If a MEDICARE coordinated family PREMIUM category has been established for a family, and one or more family members enrolled in both parts of MEDICARE dies, the family PREMIUM category in effect shall not change solely as a result of the death.

7. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is eligible for MEDICARE due to permanent kidney failure or end-stage renal disease, the PLAN shall pay as the primary payor for the first thirty months after he or she becomes eligible for MEDICARE due to the kidney disease, whether or not the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is enrolled in MEDICARE. The PREMIUM rate will be the non-MEDICARE rate during this period. MEDICARE becomes the primary payor after this thirty-month period. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of MEDICARE enrollment based on kidney disease, there is a separate thirty-month period during which this PLAN will again be the primary payor. No reduction in premium is available for active EMPLOYEES under this section.

P. CONTRACT TERMINATION

1. If WPS terminates this CONTRACT pursuant to the Professional Administrative Services Agreement, any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:

a. The CONTRACT maximum is reached.

b. The attending PHYSICIAN determines that CONFINEMENT is no longer MEDICALLY NECESSARY.

c. The end of 12 months after the date of termination.

d. CONFINEMENT ceases.

2. If the BOARD terminates this CONTRACT pursuant to the Professional Administrative Services Agreement, then all rights to BENEFITS shall cease as of the date of termination. WPS will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include but are not limited to:

a. Transferring the patient to another institution;

b. Billing the BOARD a fee for SERVICE rendered; or

c. Permitting non-plan PHYSICIANS to assume responsibility for rendering care.

The overall intent is to be in the best interest of the patient.

Q. INDIVIDUAL TERMINATION OF COVERAGE

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

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

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

c. The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage, while on a leave of absence or LAYOFF expires, as provided in Section II. K.

d. The end of the month in which a notice of cancellation of coverage is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT or a later date as specified on the cancellation of coverage notice. If the ANNUITANT or CONTINUANT contacts WPS directly to cancel coverage, WPS shall reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT.

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

f. The expiration of the 36 months for which the PARTICIPANT is allowed to continue under paragraph 4. as required by State and Federal law.

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

h. The earliest date Federal or State continuation provisions permit termination of coverage for any reason, except the BOARD specifically allows the EMPLOYEE to maintain coverage for 36 months instead of 18.

2. No refund of any PREMIUM under II. Q. e. may be made unless the EMPLOYER, or DEPARTMENT if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month for which PREMIUM has been collected or deducted.

3. Except when a PARTICIPANT'S coverage terminates because of cancellation or non-payment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if confined as an INPATIENT, but only until the attending PHYSICIAN determines that CONFINEMENT is no longer MEDICALLY NECESSARY, the CONTRACT maximum is reached, the end of 12 months after the date of termination, or CONFINEMENT ceases, whichever occurs first.

4. **a.** Except when coverage is cancelled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the EMPLOYER is not notified of the PARTICIPANT'S loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the EMPLOYER notice, whichever is later. Application must

be received by the DEPARTMENT post-marked within 60 days of the date the PARTICIPANT is notified by the EMPLOYER of the right to continue or 60 days from the date coverage ceases, whichever is later. WPS shall bill the continuing PARTICIPANT directly for the required PREMIUMS. WPS may not apply a surcharge to the PREMIUM, even if otherwise permitted under state or federal law.

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

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

6. No person other than a PARTICIPANT is eligible for health BENEFITS. The SUBSCRIBER'S rights to group health 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 coverage is available and is limited to the STANDARD PLAN subject to the waiting period for pre-existing conditions.

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

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

7. In situations where a PARTICIPANT in an alternate health plan has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory PHYSICIAN-patient relationship with the current or alternate primary care PHYSICIAN, disenrollment efforts may be initiated by the plan or the BOARD. The SUBSCRIBER disenrollment is the beginning of the month following completion of the grievance process and approval of the BOARD. Coverage will be transferred to the STANDARD PLAN, with options to enroll in alternate health care plans during subsequent dual-choice enrollment periods. Re-enrollment in the alternate plans is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

R. COVERAGE CERTIFICATION

The HEALTH BENEFIT PLAN certifies that providers listed on Addendum #2 of the "Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Program and Uniform Benefits" or on any of the HEALTH BENEFIT PLAN'S publications of providers are either under contract for all of the ensuing calendar year or the HEALTH BENEFIT

PLAN will pay charges for BENEFITS on a fee-for-service basis. Those providers have agreed to accept new patients unless specifically indicated otherwise.

S. ADMINISTRATION OF BENEFIT MAXIMUMS UNDER UNIFORM BENEFITS

1. If a PARTICIPANT changes PLANS during a CONTRACT year (e.g., due to change in residence), any annual BENEFIT maximums under Uniform Benefits will start over at $0 with the new PLAN as of the effective date of coverage with the new PLAN.

2. If a PARTICIPANT changes the level of coverage (e.g., single to family), transfers to another State agency or has a spouse-to-spouse transfer resulting in a change of SUBSCRIBER, but does not change PLANS, the annual BENEFIT maximums will continue to accumulate for that year.

3. The PLAN shall give reasonable notice to the PARTICIPANT when the PARTICIPANT has reached approximately 75% of their benefit maximum (e.g., lifetime maximum). The PLAN shall provide the PARTICIPANT with BENEFIT accumulations upon request. This requirement can be satisfied through mailing of a plan explanation of benefits.

III. STANDARD PLAN SCHEDULE OF BENEFITS

The following limitations apply to all HEALTH CARE SERVICES received from PREFERRED PROVIDERS and HEALTH CARE PROVIDERS other than PREFERRED PROVIDERS and that are covered BENEFITS under Section IV.

A. DEDUCTIBLE

If any portion of the DEDUCTIBLE is incurred during the last three months of a CALENDAR YEAR that portion will be applied toward the PARTICIPANT'S DEDUCTIBLE for the next CALENDAR YEAR.

If two or more PARTICIPANTS under the same FAMILY COVERAGE incur expenses for BENEFITS as a result of INJURIES received in the same accident, only one DEDUCTIBLE is required for all BENEFITS related to that accident.

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

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

The annual DEDUCTIBLE amount is $100.00 per PARTICIPANT, not to exceed $200.00 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated in paragraph 2. will NOT be used to satisfy this annual DEDUCTIBLE amount. The annual deductible amounts do not apply to the treatment of alcoholism, drug abuse and nervous or mental disorders.

2. Annual DEDUCTIBLE Amount for HEALTH CARE SERVICES Provided by a HEALTH CARE PROVIDER Other Than a PREFERRED PROVIDER.

The annual DEDUCTIBLE amount is $500.00 per PARTICIPANT, not to exceed $1,000.00 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated in paragraph 1. will NOT be used to satisfy this annual DEDUCTIBLE amount. The annual deductible amounts do not apply to the treatment of alcoholism, drug abuse and nervous or mental disorders.

B. COINSURANCE

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

After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER at 100%, unless specifically stated otherwise in the PLAN.

2. COINSURANCE for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a HEALTH CARE PROVIDER Other Than a PREFERRED PROVIDER.

After the DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER at 80%, unless specifically stated otherwise in the PLAN, up to the annual out-of-pocket limit stated below.

3. COINSURANCE for Independent Anesthesiologists.

After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 100% of the CHARGES for HEALTH CARE SERVICES provided and billed by an independent anesthesiologist, unless specifically stated otherwise in the PLAN.

4. COINSURANCE for Radiology, Pathology and Laboratory Services.

After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 100% of the CHARGES for radiology, pathology and laboratory services for TREATMENT of an ILLNESS or INJURY and for routine SERVICES. This includes x-rays, laboratory services, allergy testing, MRI's, CT scans, pap smears and mammograms.

5. COINSURANCE for HOSPITAL Emergency Room Visits.

After the preferred annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 100% of the CHARGES for the emergency room fee billed by the HOSPITAL for use of the HOSPITAL emergency room, PHYSICIAN'S PROFESSIONAL SEVICES and MISCELLANEOUS HOSPITAL EXPENSES for HEALTH CARE SERVICES provided during the visit to the HOSPITAL emergency room.

C. ANNUAL OUT-OF-POCKET LIMIT

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

The annual out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER is $100 per PARTICIPANT, not to exceed $200 per family. This total is made up of the annual DEDUCTIBLE amount for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph 2. below will NOT be used to satisfy this annual out-of-pocket limit.

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

After the applicable annual out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in the PLAN, incurred by the PARTICIPANT during the remainder of the CALENDAR YEAR, subject to the lifetime maximum benefit limit and all other terms, conditions and provisions of the PLAN. This paragraph does not apply to BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS. BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall continue to be payable as specifically stated elsewhere in the PLAN.

2. Annual Out-Of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a HEALTH CARE PROVIDER Other Than a PREFERRED PROVIDER.

The annual out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER is $2,000 per PARTICIPANT, not to exceed $4,000 per family. This total is made up of the annual DEDUCTIBLE and COINSURANCE amounts for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph 1. above will NOT be used to satisfy this annual out-of-pocket limit.

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

After the applicable annual out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in the PLAN, incurred by the PARTICIPANT during the remainder of the CALENDAR YEAR, subject to the lifetime maximum benefit limit and all other terms, conditions and provisions of the PLAN. This paragraph does not apply to BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS. BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall continue to be payable as specifically stated elsewhere in the PLAN.

D. LIFETIME MAXIMUM BENEFITS

The PARTICIPANT lifetime maximum BENEFIT limit is the total amount of BENEFITS payable for all covered ILLNESSES and INJURIES for each PARTICIPANT and is $2,000,000. The PARTICIPANT lifetime maximum BENEFIT limit applies to all covered expenses incurred during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the PLAN. No benefits are payable for expenses incurred for HEALTH CARE SERVICES provided to a PARTICIPANT either before that PARTICIPANT'S EFFECTIVE DATE of coverage under the PLAN or after that PARTICIPANT'S coverage has terminated under the PLAN. In no event will the PLAN pay more than the PARTICIPANT lifetime maximum BENEFIT limit.

IV. STANDARD PLAN HOSPITAL, PROFESSIONAL AND OTHER SERVICES

Subject to the annual DEDUCTIBLE amounts stated in Section III., BENEFITS are payable as stated in subsection B. and C. of Section III. for CHARGES for covered expenses a PARTICIPANT incurs in connection with a covered ILLNESS, INJURY or specific routine/preventive services, subject to all the provisions of the PLAN. Covered expenses must be incurred while the PARTICIPANT is covered under the PLAN. The DEDUCTIBLE must be satisfied for the CALENDAR YEAR in which the covered expenses are incurred before BENEFITS are payable, unless specifically stated otherwise in the PLAN.

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

BENEFITS for CHARGES for covered CONFINEMENTS are subject to: (1) preadmission and continued stay certification requirements; and (2) the reductions in benefits shown in Section X. for failure to comply with the certification requirements. Please see Section X. Value Care Program.

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

A. HOSPITAL SERVICES

Except as excluded in Sections VIII., IX., and XII., BENEFITS are payable for CHARGES for the following HOSPITAL SERVICES for each PARTICIPANT admitted to a HOSPITAL or EXTENDED CARE FACILITY on or after his/her EFFECTIVE DATE, if those SERVICES are consistent with and MEDICALLY NECESSARY for the diagnosis and TREATMENT of the PARTICIPANT, as determined by WPS.

1. PHYSICAL ILLNESS or INJURY.

a. **CONFINEMENT in a HOSPITAL** . This applies to those PARTICIPANTS admitted as INPATIENT in a HOSPITAL for TREATMENT of a PHYSICAL ILLNESS or INJURY, other than alcoholism, drug abuse and NERVOUS and MENTAL DISORDERS.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 365 days per CONFINEMENT.

(1) CHARGES for room and board for occupancy of semiprivate or lesser accommodations. Covered CHARGES shall include tube feedings in lieu of tray SERVICE when MEDICALLY NECESSARY, but not both. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(2) CHARGES for nursing services;

(3) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES; and

(4) CHARGES for intensive care unit room and board.

With respect to CONFINEMENTS for pregnancy, the PLAN shall not limit the length of stay to less than: (1) 48 hours for a normal birth; and (2) 96 hours for cesarean delivery. However, a PARTICIPANT is free to leave the HOSPITAL earlier if the decision to shorten the stay is the mutual decision of the PHYSICIAN and mother.

b. **CONFINEMENT in an EXTENDED CARE FACILITY.** BENEFITS are limited to two days of CONFINEMENT for each unused HOSPITAL .day following a

HOSPITAL CONFINEMENT described above, available only if PARTICIPANT is transferred from CONFINEMENT in a HOSPITAL to an EXTENDED CARE FACILITY.

c. **BENEFIT levels.** The BENEFIT levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in BENEFIT levels during the CONFINEMENT. If the PARTICIPANT is transferred to another HOSPITAL or other facility for continued TREATMENT of the same or related ILLNESS or INJURY, it's still just one CONFINEMENT.

2. Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS.

Notwithstanding paragraphs 3. and 4. below, this paragraph 2. applies to those PARTICIPANTS admitted as INPATIENTS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable at 100% of the CHARGES for up to 30 days CONFINEMENT per PARTICIPANT per CALENDAR YEAR. This benefit applies to all HEALTH CARE SERVICES provided to a PARTICIPANT during the CONFINEMENT. BENEFITS payable under this paragraph 2. will reduce those BENEFITS payable under paragraphs 3. and 4. See paragraph 5. for alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS maximums.

3. NERVOUS OR MENTAL DISORDERS.

a. **CONFINEMENT in a GENERAL HOSPITAL.** This applies to those PARTICIPANTS admitted as resident patients in a GENERAL HOSPITAL for TREATMENT of NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 120 days per CONFINEMENT.

When successive CONFINEMENTS in one or more GENERAL HOSPITALS occur with less than 60 days between any discharge and the next admission, they shall constitute one period of CONFINEMENT. The 120-day BENEFIT limit will be reduced by any BENEFITS payable under subsection A., 2., above.

(1) CHARGES for room and board for occupancy of semiprivate or lesser accommodations. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(2) CHARGES for nursing services; and

(3) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES.

b. **CONFINEMENT in a SPECIALTY HOSPITAL.** This applies to those PARTICIPANTS admitted as resident patients in a SPECIALTY HOSPITAL for TREATMENT of NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable for CHARGES for up to $50.00 a day for HOSPITAL expenses actually incurred during the first 120 days per CONFINEMENT.

When successive CONFINEMENTS in one or more GENERAL HOSPITALS occur with less than 60 days between any discharge and the next admission, they shall constitute one period of CONFINEMENT. The 120 day BENEFIT limit will be reduced by any BENEFITS payable under subsection A. 2., above.

Total BENEFITS payable under a. and b., above, will not exceed 120 days per CONFINEMENT, renewable after 60 days separation.

c. **CONFINEMENT in an EXTENDED CARE FACILITY.** BENEFITS are limited to two days of CONFINEMENT for each unused HOSPITAL or SPECIALTY HOSPITAL day following a HOSPITAL CONFINEMENT described above, available only if a PARTICIPANT is transferred from CONFINEMENT in a HOSPITAL or SPECIALTY HOSPITAL to an EXTENDED CARE FACILITY.

4. Alcoholism and Drug Abuse.

a. **CONFINEMENT in a GENERAL HOSPITAL.** This applies to those PARTICIPANTS admitted as resident patients in a GENERAL HOSPITAL for TREATMENT of alcoholism and drug abuse.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 365 days per CONFINEMENT. The 365-day BENEFIT limit will be reduced by any BENEFITS payable under section A., 2., above.

(1) CHARGES for room and board, for occupancy of semiprivate or lesser accommodations. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(2) CHARGES for nursing services; and

(3) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES.

b. **CONFINEMENT in a SPECIALTY HOSPITAL.** This applies to those PARTICIPANTS admitted as resident patients in a SPECIALTY HOSPITAL for TREATMENT of alcoholism and drug abuse.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred for up to 30 days per CALENDAR YEAR. This BENEFIT limit will be reduced by any BENEFITS payable under subsection A., 2., above.

(1) CHARGES for room and board for occupancy of semiprivate or lesser accommodations. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(2) CHARGES for nursing services; and

(3) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES.

5. Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS Maximums.

Total BENEFITS payable for INPATIENT alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS will not exceed $6,300.00 per PARTICIPANT per CALENDAR YEAR.

Total BENEFITS payable for all BENEFITS under the Plan for TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall not exceed the annual maximum of $7,000.00 per PARTICIPANT per CALENDAR YEAR.

Note: Annual dollar maximums for TREATMENT of NERVOUS OR MENTAL DISORDERS only are suspended.

Annual dollar maximums remain in force for TREATMENT of alcoholism and drug abuse. Any BENEFITS paid during the year for TREATMENT of NERVOUS OR MENTAL DISORDERS will be applied toward the annual BENEFIT maximum for alcoholism and

drug abuse TREATMENT when determining whether BENEFITS for alcoholism and drug **abuse** TREATMENT remain available.

B. OUTPATIENT MISCELLANEOUS HOSPITAL EXPENSES

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

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

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

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

4. Laboratory tests and X-ray examinations, including routine laboratory tests and x-ray examinations.

5. X-ray and radiation.

C. PROFESSIONAL AND OTHER SERVICES

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

1. SURGICAL SERVICES.

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

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

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

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

(1) Within the past twelve months, there must be appropriate documentation of at least six consecutive months of adherence to a professionally supervised weight loss program. Failure to achieve and maintain 10% weight loss must be demonstrated. Documentation must consist of actual progress notes for the dates of participation in the program. Participation which is summarized in the form of a letter is not acceptable. Appropriate documentation is as follows:

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

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

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

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

(2) Eight week trial of pharmacotherapy (unless the pharmacotherapy is contraindicated)

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

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

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

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

(5)~~**(1)**~~ prior authorization is received from WPS.~~; and~~

(6) there has been no previous bariatric surgery performed;

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

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

(b) Type 2 diabetes requiring medication for treatment;

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

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

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

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

(g) Severe sleep apnea (AHI greater than 40)

~~**(2)** the PARTICIPANT suffers from MORBID OBESITY and one of the following: (a) hypertension (diastolic greater than 100 consistently); (b) hyperlipidemia (cholesterol greater than 300); (c) diabetes requiring medication; or (d) joint pain with degenerative changes of joint(s) as evidenced by x-ray;~~

~~**(3)** in the last 24 months, there has been a consistent program that is PHYSICIAN supervised with integrated components of a dietary regimen, appropriate exercise and behavioral modification and support;~~

~~**(4)** there has been a full trial of a lipase inhibitor (such as orlistat) or other medication recommended;~~

~~**(5)** an evaluation has been performed by a multi-disciplinary team with medical, surgical, psychiatric and nutritional expertise;~~

~~**(6)** there has been no previous bariatric surgery performed; and~~

~~**(7)** the surgery would be performed by a surgeon substantially experienced with appropriate procedures and working in a clinical setting with adequate support for all aspects of management and assessment.~~

BENEFITS are not payable for the following surgeries: (a) biliopancreatic bypass without duodenal switch; (b) jejunoileal bypass; ~~(c) ileal bypass; and~~ (c) long limb (greater than 150 cm) gastric bypass; (d) mini gastric bypass (Billroth procedure); (e) Fobi pouch; and (f) bariatric surgery for the management and treatment of GERD and cholecystitis.~~(d) gastric balloon.~~

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

b. BENEFITS are payable for a covered surgical procedure that requires a surgical assistant to be present, as determined by WPS, only as follows. If WPS determines BENEFITS are payable for the SERVICES directly provided to a PARTICIPANT by a surgical assistant: (1) BENEFITS for the covered services of a PHYSICIAN surgical assistant will be paid up to a maximum of 15% of the charge WPS determines for that surgical procedure performed by the PHYSICIAN; and (2) BENEFITS for the covered services of a surgical assistant who is not a PHYSICIAN will be paid up to a maximum of 10% of the CHARGE WPS determines for that surgical procedure performed by the PHYSICIAN.

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

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

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

2. MATERNITY SERVICES.

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

3. MEDICAL SERVICES.

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

4. Anesthesia SERVICES.

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

5. Radiation Therapy and Chemotherapy SERVICES.

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

6. Diagnostic SERVICES.

Diagnostic radiology and laboratory SERVICES directly provided to a PARTICIPANT for radiology and lab tests related to a covered PHYSICAL ILLNESS or INJURY.

7. ORAL SURGERY SERVICES.

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

(a) surgical exposure or removal of impacted teeth;

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

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

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

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

(f) frenectomy;

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

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

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

(j) alveolectomy/alveoplasty;

(k) orthognathic surgery and osteotomies;

(l) apical curettage;

(m) gingival curettage under general anesthesia;

(n) removal of residual (retained) root;

(o) TREATMENT of fractured facial bones;

(p) vestibuloplasty;

(q) osteoplasty;

(r) transeptal fiberotomy;

(s) retrograde filling;

(t) hemisection;

(u) coronidectomy; and

(v) surgical removal of erupted teeth.

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

8. EMERGENCY MEDICAL CARE.

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

(a) Acute allergic reactions;

(b) Acute asthmatic attacks;

(c) Convulsions;

(d) Epileptic seizures;

(e) Acute Hemorrhage;

(f) Acute appendicitis;

(g) Acute or suspected poisoning;

(h) Coma;

(i) Heart attack;

(j) Attempted suicide;

(k) Suffocation;

(l) Stroke;

(m) Drug overdoses;

(n) Loss of consciousness;

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

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

a. **OUTPATIENT TREATMENT of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS.** TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS for a PARTICIPANT other than as an INPATIENT is limited to 90% of the first $2,000.00 in CHARGES during any CALENDAR YEAR.

Such TREATMENT must be provided by a PHYSICIAN, a licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or who is certified by the American Board of Professional Psychology a facility established and maintained according to rules promulgated under Wis. Stats. § 51.42 (7) (b), or a medical clinic or billed by a psychologist under the direction of a PHYSICIAN.

b. **TRANSITIONAL TREATMENT ARRANGEMENTS.** Each CALENDAR YEAR, BENEFITS are payable at 90% of the first $3,000.00 of CHARGES for covered expenses incurred by a PARTICIPANT in that CALENDAR YEAR for TRANSITIONAL TREATMENT ARRANGEMENTS provided to that PARTICIPANT up to $2,700.00 in each CALENDAR YEAR.

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

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

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

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

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

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

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

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

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

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

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

c. Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS Maximum. Total BENEFITS payable for all TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall not exceed the annual maximum of $7,000.00 per PARTICIPANT per CALENDAR YEAR.

Note: Annual dollar maximums for TREATMENT of NERVOUS OR MENTAL DISORDERS only are suspended.

Annual dollar maximums remain in force for TREATMENT of alcoholism and drug abuse. Any BENEFITS paid during the year for TREATMENT of NERVOUS OR MENTAL DISORDERS will be applied toward the annual BENEFIT maximum for alcoholism and drug abuse TREATMENT when determining whether BENEFITS for alcoholism and drug abuse TREATMENT remain available.

d. Psychiatric therapy SERVICES provided to INPATIENTS for TREATMENT of NERVOUS OR MENTAL DISORDERS.

10. Ambulance SERVICE.

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

11. TREATMENT of Temporomandibular Disorders.

BENEFITS are payable for diagnostic procedures and surgical or non-surgical TREATMENT for the correction of temporomandibular disorders, if all of the following apply:

a. A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

b. The procedure or device is reasonable and appropriate for the diagnosis or TREATMENT of the condition under the accepted standards of the profession of the health care provider rendering the SERVICE.

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

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

12. Routine Physical Examinations.

Benefits are payable for routine physical examinations and related diagnostic services performed and billed by a PHYSICIAN. Physical examinations requested by a third party are not covered under this CONTRACT.

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

Physical, speech, occupational, respiratory and aquatic therapy when necessitated by an ILLNESS or INJURY by a PHYSICIAN, licensed physical, speech, occupational or respiratory therapist or any other HEALTH CARE PROVIDER approved by WPS other than one whom ordinarily resides in the PARTICIPANT'S home or who is a member of the PARTICIPANT'S IMMEDIATE FAMILY.

14. Special Duty Nursing.

Special duty nursing by a registered or licensed practical nurse other than one who ordinarily resides in the PARTICIPANT'S home or who is a member of the PARTICIPANT'S IMMEDIATE FAMILY.

15. Dental SERVICES.

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

BENEFITS are also payable for HOSPITAL or ambulatory surgery center CHARGES incurred, and anesthetics provided, in conjunction with dental care that is provided to a PARTICIPANT in a HOSPITAL or ambulatory surgery center provided: (1) the PARTICIPANT is a child under the age of five; (2) the PARTICIPANT has a chronic disability that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or (3) the PARTICIPANT has a medical condition that requires hospitalization or general anesthesia for dental care.

16. MEDICAL SUPPLIES.

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

a. Blood or blood plasma;

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

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

d. oxygen; and

e. rental of radium and radioactive isotopes.

17. DURABLE MEDICAL EQUIPMENT.

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

18. OUTPATIENT Cardiac Rehabilitation SERVICES.

BENEFITS are payable for OUTPATIENT cardiac rehabilitation SERVICES. SERVICES must be approved by WPS and provided in an OUTPATIENT department of a HOSPITAL, in a medical center or clinic program. This BENEFIT applies only to PARTICIPANTS with a recent history of:

a. a heart attack (myocardial infarction);

b. coronary bypass surgery;

c. onset of angina pectoris;

d. heart valve surgery;

e. onset of decubital angina;

f. onset of unstable angina;

g. percutaneous transluminal angioplasty; or

h. any other condition for which WPS determines cardiac rehabilitation as being appropriate for treating a PARTICIPANT'S medical condition.

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

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

19. Home Attendance.

BENEFITS are payable for CHARGES for home attendance and care recommended by the attending PHYSICIAN and provided by other than a registered or licensed practical nurse or a member of the PARTICIPANT'S family. The maximum BENEFIT limit is 150

days at $10.00 per day during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the CONTRACT.

20. BIOLOGICALS.

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

21. Licensed Free-Standing Surgical Center.

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

22. Mammograms and Pap Smears.

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

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

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

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

23. Equipment and Supplies for TREATMENT of Diabetes.

BENEFITS are payable for CHARGES incurred for the installation and use of an insulin infusion pump, and all other equipment and supplies, excluding insulin and disposable diabetic supplies, used in the TREATMENT of diabetes. This benefit is limited to the purchase of one pump per PARTICIPANT per CALENDAR YEAR. The PARTICIPANT must use the pump for at least 30 days before the pump is purchased. BENEFITS are also payable for CHARGES for diabetic self-management education programs.

24. Immunizations.

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

25. Blood Lead Tests.

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

26. Breast Reconstruction Following Mastectomy.

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

27. Certified Nurse Midwife Services.

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

28. Contraceptives.

BENEFITS are payable for Intrauterine devices (IUD); diaphragms, and injections of medication for birth control, and related HEALTH CARE SERVICES. Subdermal contraceptive implants (Norplant) are not covered.

V. SMP BENEFITS

This Section applies to State of Wisconsin eligible EMPLOYEES and their eligible DEPENDENTS who have elected the SMP.

For those EMPLOYEES AND DEPENDENTS who elected the SMP, BENEFITS are those described in the "Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits" that are in effect at the time HEALTH CARE SERVICES are provided to a PARTICIPANT.

If the PARTICIPANT does not reside in a county listing a PRIMARY PHYSICIAN for the SUBSCRIBER'S PLAN at the time continuation coverage is elected, the PARTICIPANT may elect a participating PLAN in the county where the PARTICIPANT resides.

To be eligible for SMP benefits, all of the following apply:

A. Participants under the age of 65 and/or not eligible for Medicare as the primary payor are eligible to participate in the SMP on the date they become participants.

B. The requirements that a participant must be under age 65 and/or not eligible for Medicare is deferred until the participant's termination of employment with the State of Wisconsin.

C. A participant whose participation in the SMP terminates because of Medicare eligibility automatically becomes a participant under the Medicare Plus $1,000,000 coverage.

D. The BOARD will determine the geographical area where the SMP may be offered.

E. Employees must reside or work in an SMP county to be eligible.

VI. WISCONSIN PUBLIC EMPLOYERS STANDARD PLAN

This CONTRACT also applies to local public EMPLOYERS and EMPLOYEES who have elected to participate in the WISCONSIN PUBLIC EMPLOYERS Group Health Program pursuant to Wis. Stats. § 40.51 (7), and the administrative GUIDELINES approved by the BOARD. References in this CONTRACT to BOARD EMPLOYEES and BOARD agencies are construed to mean local public EMPLOYERS, EMPLOYEES and ANNUITANTS, respectively. The following apply only to local public EMPLOYERS, EMPLOYEES and ANNUITANTS covered under this CONTRACT.

Section VII. does not apply to this Section.

A. GROUP ADMINISTRATION

The provisions of Section II. apply to this Section VI., except that Section II. B. 2. is deleted and replaced by:

An EMPLOYEE shall be covered if a completed DEPARTMENT application form is received by the EMPLOYER, within 30 days of being hired to be effective on the first day of the month that begins on or after receipt of the application by the EMPLOYER or, if received on or before becoming eligible for EMPLOYER contribution toward PREMIUM to be effective upon becoming eligible for EMPLOYER contribution toward premium. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements.

B. BENEFITS

The following BENEFITS apply only to this Section VI.

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

The following HEALTH CARE SERVICES are covered expenses. All HEALTH CARE SERVICES must be MEDICALLY NECESSARY and ordered by a PHYSICIAN because of a covered ILLNESS or INJURY, except for covered routine/preventive services. Covered expenses must be incurred while the PARTICIPANT is covered under the PLAN. BENEFITS are not payable for MAINTENANCE THERAPY, CUSTODIAL CARE, SUPPORTIVE CARE, or any HEALTH CARE SERVICE to which an exclusion applies.

1. INPATIENT HOSPITAL SERVICES

Except as excluded in Sections VIII., IX., and XII. , BENEFITS are payable for CHARGES for HOSPITAL SERVICES for each PARTICIPANT admitted to a HOSPITAL, SPECIALTY HOSPITAL or EXTENDED CARE FACILITY on or after his/her EFFECTIVE DATE if SERVICES are consistent with and MEDICALLY NECESSARY for admission, diagnosis and TREATMENT, as determined by WPS.

Per diem expenses are payable at 100% of the CHARGES, except when a private room is occupied, no more than the average of the institution's CHARGES for all of its two bed rooms is payable. 100% of the CHARGES for a HOSPITAL'S intensive care unit will be paid. Additional payments for HOSPITAL SERVICES may be available under subsection B. 4., below, after the DEDUCTIBLE is met.

a. PHYSICAL ILLNESS or INJURY.

(1) CONFINEMENT in a HOSPITAL. This applies to those PARTICIPANTS admitted as resident patients in a HOSPITAL for TREATMENT of a PHYSICAL ILLNESS or INJURY, other than alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 365 days per CONFINEMENT.

(a) CHARGES for room and board for occupancy of semiprivate or lesser accommodations. Covered CHARGES shall include tube feedings in lieu of tray SERVICE when MEDICALLY NECESSARY, but not both. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(b) CHARGES for nursing services;

(c) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES; and

(d) CHARGES for intensive care unit room and board.

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

(2) CONFINEMENT in an EXTENDED CARE FACILITY. BENEFITS are limited to two days of CONFINEMENT for each unused HOSPITAL day following a HOSPITAL CONFINEMENT described above, available only if a PARTICIPANT is transferred from CONFINEMENT in a HOSPITAL to an EXTENDED CARE FACILITY. Total BENEFITS payable under this paragraph will not exceed 120 days per CONFINEMENT.

(3) BENEFIT Levels. The BENEFIT levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in BENEFIT levels during the CONFINEMENT. If the PARTICIPANT is transferred to another HOSPITAL or other facility for continued treatment of the same or related ILLNESS or INJURY, it's still just one CONFINEMENT.

b. Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS. This paragraph applies to those PARTICIPANTS admitted as resident patients for TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable at 100% of the CHARGES for up to 30 days CONFINEMENT per PARTICIPANT per CALENDAR YEAR. This benefit applies to all HEALTH CARE SERVICES provided to a PARTICIPANT during the CONFINEMENT. Benefits payable under this paragraph b. will reduce those BENEFITS payable under paragraphs c. and d. See paragraph e. for alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS maximums.

c. NERVOUS OR MENTAL DISORDERS.

(1) CONFINEMENT in a GENERAL HOSPITAL. This applies to those PARTICIPANTS admitted as resident patients in a GENERAL HOSPITAL for TREATMENT of NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 120 days per CONFINEMENT.

When successive CONFINEMENTS in one or more GENERAL HOSPITALS occur with less than 60 days between any discharge and the next admission, they shall constitute one period of CONFINEMENT. The 120-day BENEFIT limit will be reduced by any BENEFITS payable under section B. 1. b., above.

(a) CHARGES for room and board for occupancy of semiprivate or lesser accommodations. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(b) CHARGES for nursing services; and

(c) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES.

(2) CONFINEMENT in a SPECIALTY HOSPITAL. This applies to those PARTICIPANTS admitted as resident patients in a SPECIALTY HOSPITAL for TREATMENT of NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable for CHARGES for up to $50.00 a day for HOSPITAL expenses actually incurred during the first 120 days per CONFINEMENT.

When successive CONFINEMENTS in one or more GENERAL HOSPITALS occur with less than 60 days between any discharge and the next admission, they shall constitute one period of CONFINEMENT. The 120-day BENEFIT limit will be reduced by any BENEFITS payable under Section B. 1. b., above.

(3) CONFINEMENT in an EXTENDED CARE FACILITY. BENEFITS are limited to two days of CONFINEMENT for each unused HOSPITAL day following a HOSPITAL CONFINEMENT described above , available only if a PARTICIPANT is transferred from CONFINEMENT in a HOSPITAL to an EXTENDED CARE FACILITY. Total BENEFITS payable under this paragraph will not exceed 120 days per CONFINEMENT.

Total BENEFITS payable under (1) and (2) above will not exceed 120 days per CONFINEMENT, renewable after 60 days separation.

d. Alcoholism and Drug Abuse.

(1) CONFINEMENT in a GENERAL HOSPITAL. This applies to those PARTICIPANTS admitted as resident patients in a GENERAL HOSPITAL for TREATMENT of alcoholism and drug abuse.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 365 days per CONFINEMENT. The 365-day BENEFIT limit will be reduced by any BENEFITS payable under Section B. 1. b., above.

(a) CHARGES for room and board for occupancy of semiprivate or lesser accommodations. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(b) CHARGES for nursing services; and

(c) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES.

(2) **CONFINEMENT in a SPECIALTY HOSPITAL.** This applies to those PARTICIPANTS admitted as resident patients in a SPECIALTY HOSPITAL for TREATMENT of alcoholism and drug abuse.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred for up to 30 days per CALENDAR YEAR. This BENEFIT limit will be reduced by any BENEFITS payable under Section B. 1. b., above.

(a) CHARGES for room and board for occupancy of semiprivate or lesser accommodations. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(b) CHARGES for nursing services; and

(c) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES.

(3) **CONFINEMENT in an EXTENDED CARE FACILITY.** BENEFITS are limited to two days of CONFINEMENT for each unused HOSPITAL day following a HOSPITAL CONFINEMENT described above, available only if a PARTICIPANT is transferred from CONFINEMENT in a HOSPITAL to an EXTENDED CARE FACILITY. Total BENEFITS payable under this paragraph will not exceed 120 days per CONFINEMENT.

e. **Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS Maximums.** Total BENEFITS payable for INPATIENT alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS will not exceed $6,300.00 per PARTICIPANT per CALENDAR YEAR.

Total BENEFITS payable for all BENEFITS under the PLAN for TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall not exceed the annual maximum of $7,000.00 per PARTICIPANT per CALENDAR YEAR.

Note: Annual dollar maximums for TREATMENT of NERVOUS OR MENTAL DISORDERS only are suspended.

Annual dollar maximums remain in force for TREATMENT of alcoholism and drug abuse. Any BENEFITS paid during the year for TREATMENT of NERVOUS OR MENTAL DISORDERS will be applied toward the annual BENEFIT maximum for alcoholism and drug abuse TREATMENT when determining whether BENEFITS for alcoholism and drug abuse TREATMENT remain available.

f. **Dental Services.** BENEFITS are also payable for HOSPITAL or ambulatory surgery center CHARGES incurred, and anesthetics provided, in conjunction with dental care that is provided to a PARTICIPANT in a HOSPITAL or ambulatory surgery center provided: (1) the PARTICIPANT is a child under the age of five; (2) the PARTICIPANT has a chronic disability that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or (3) the PARTICIPANT has a medical condition that requires hospitalization or general anesthesia for dental care.

2. OUTPATIENT MISCELLANEOUS HOSPITAL EXPENSES.

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

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

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

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

d. Laboratory tests and x-ray examinations, including routine laboratory tests and x-ray examinations. .

e. X-ray and radiation.

f. Facility fees for HEALTH CARE SERVICES provided in a licensed free-standing surgical center.

3. PROFESSIONAL and OTHER SERVICES.

Except as excluded in Sections VIII., IX., and XII., BENEFITS are payable for CHARGES for the following PROFESSIONAL SERVICES and OTHER SERVICES at 100% for each PARTICIPANT on or after his/her EFFECTIVE DATE, if those SERVICES are consistent with and MEDICALLY NECESSARY for the diagnosis and TREATMENT of the PARTICIPANT, as determined by WPS.

The aggregate maximum payment under this paragraph 3. is $10,000.00 per PARTICIPANT per PHYSICAL ILLNESS or INJURY. Additional CHARGES for PROFESSIONAL SERVICES and OTHER SERVICES may be payable under paragraph 4. below after the DEDUCTIBLE is met.

a. SURGICAL SERVICES, other than ORAL SURGERY SERVICES, wherever performed. BENEFITS for ORAL SURGERY SERVICES are shown in paragraph 3. g. below.

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

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

(a) Within the past twelve months, there must be appropriate documentation of at least six consecutive months of adherence to a professionally supervised weight loss program. Failure to achieve and maintain 10% weight loss must be demonstrated. Documentation must consist of actual progress notes for the dates of participation in the program. Participation which is summarized in the form of a letter is not acceptable. Appropriate documentation is as follows:

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

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

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

iv. If, on the date of the initial evaluation of the patient at the bariatric surgery program, there is no documentation of i., or ii. or iii. above, then there must bedocumentation in the bariatric surgery notes that the patient has been prospectively referred to a professionally supervised weight loss program for a minimum of six consecutive months.

(b) Eight week trial of pharmacotherapy (unless the pharmacotherapy is contraindicated)

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

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

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

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

(e) prior authorization is received from WPS.

(f) there has been no previous bariatric surgery performed;

(g) For PARTICIPANTS with a five year history of BMI greater than 35, one of the following comorbid conditions must be documented:

i. Coronary artery disease or obesity-related cardiomyopathy requiring medical management;

ii. Type 2 diabetes requiring medication for treatment;

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

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

v. Dyslipidemia (LDL cholesterol greater than 130 for non-diabetic patients or greater than 100 in diabetic patients that during the past six months has not been significantly

reduced despite increased dosages of lipid-lowering agents or a three month trial of at least two different lipid-lowering agents)

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

vii. Severe sleep apnea (AHI greater than 40)

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

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

~~**(a)** prior authorization is received from WPS; and~~

~~**(b)** the PARTICIPANT suffers from MORBID OBESITY and one of the following: (1) hypertension (diastolic greater than 100 consistently); (2) hyperlipidemia (cholesterol greater than 300); (3) diabetes requiring medication; or (4) joint pain with degenerative changes of joint(s) as evidenced by x-ray;~~

~~**(c)** in the last 24 months, there has been a consistent program that is PHYSICIAN supervised with integrated components of a dietary regimen, appropriate exercise and behavioral modification and support;~~

~~**(d)** there has been a full trial of a lipase inhibitor (such as orlistat) or other medication recommended;~~

~~**(e)** an evaluation has been performed by a multi-disciplinary team with medical, surgical, psychiatric and nutritional expertise;~~

~~**(f)** there has been no previous bariatric surgery performed; and~~

~~**(g)** the surgery would be performed by a surgeon substantially experienced with appropriate procedures and working in a clinical setting with adequate support for all aspects of management and assessment.~~

~~BENEFITS are not payable for the following surgeries: (a) biliopancreatic bypass; (b) jejunoileal bypass; (c) ileal bypass; and (d) gastric balloon.~~

(2) BENEFITS are payable for a covered surgical procedure that requires a surgical assistant to be present, as determined by WPS, only as follows. If WPS determines BENEFITS are payable for the SERVICES directly

provided to a PARTICIPANT by a surgical assistant: (1) BENEFITS for the covered services of a PHYSICIAN surgical assistant will be paid up to a maximum of 15% of the charge WPS determines for that surgical procedure performed by the PHYSICIAN; and (2) BENEFITS for the covered services of a surgical assistant who is not a PHYSICIAN will be paid up to a maximum of 10% of the CHARGE WPS determines for that surgical procedure performed by the PHYSICIAN.

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

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

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

b. MATERNITY SERVICES, including: (1) prenatal and postnatal care; (2) laboratory procedures; (3) delivery of the newborn natural child; (4) cesarean sections; and (5) HEALTH CARE SERVICES for miscarriages.

c. MEDICAL SERVICES provided to an INPATIENT and to a PARTICIPANT receiving HOME CARE SERVICES.

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

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

f. Diagnostic radiology and laboratory SERVICES directly provided to a PARTICIPANT for radiology and lab tests related to a covered PHYSICAL ILLNESS or INJURY. BENEFITS are also payable for routine radiology and

laboratory services provided to a PARTICIPANT, including blood lead tests for PARTICIPANTS age five and under.

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

(1) surgical exposure or removal of impacted teeth;

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

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

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

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

(6) frenectomy;

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

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

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

(10) alveolectomy/alveoplasty;

(11) orthognathic surgery and osteotomies;

(12) apical curettage;

(13) gingival curettage under general anesthesia;

(14) removal of residual (retained) root;

(15) TREATMENT of fractured facial bones;

(16) vestibuloplasty;

(17) osteoplasty;

(18) transeptal fiberotomy;

(19) retrograde filling;

(20) hemisection;

(21) coronidectomy; and

(22) surgical removal of erupted teeth.

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

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

(1) Acute allergic reactions

(2) Acute asthmatic attacks

(3) Convulsions

(4) Epileptic seizures

(5) Acute Hemorrhage

(6) Acute appendicitis

(7) Acute or suspected poisoning

(8) Coma

(9) Heart attack

(10) Attempted suicide

(11) Suffocation

(12) Stroke

(13) Drug overdoses

(14) Loss of consciousness

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

i. Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDER TREATMENT as follows:

(1) **OUTPATIENT TREATMENT of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS.** TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS for a PARTICIPANT other than as an INPATIENT is limited to 90% of the first $2,000.00 in CHARGES during any CALENDAR YEAR.

Such TREATMENT must be provided by a PHYSICIAN, a licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or who is certified by the American Board of Professional Psychology, a facility established and maintained according to rules promulgated under Wis. Stats. § 51.42 (7) (b), or a medical clinic or billed by a psychologist under the direction of a PHYSICIAN.

(2) **TRANSITIONAL TREATMENT ARRANGEMENTS.** Each CALENDAR YEAR, BENEFITS are payable at 90% of the first $3,000.00 of CHARGES for covered expenses incurred by a PARTICIPANT in that CALENDAR YEAR for TRANSITIONAL TREATMENT ARRANGEMENTS provided to that PARTICIPANT up to $2,700.00 in each CALENDAR YEAR.

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

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

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

(c) specific diagnosis is consistent with the symptoms;

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

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

(f) see the definition of "MEDICALLY NECESSARY" in the Definitions.

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

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

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

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

(3) **Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS Maximum.** Total BENEFITS payable for all TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall not exceed the annual maximum of $7,000.00 per PARTICIPANT per CALENDAR YEAR.

Note: Annual dollar maximums for TREATMENT of NERVOUS OR MENTAL DISORDERS only are suspended.

Annual dollar maximums remain in force for TREATMENT of alcoholism and drug abuse. Any BENEFITS paid during the year for TREATMENT of NERVOUS OR MENTAL DISORDERS will be applied toward the annual BENEFIT maximum for alcoholism and drug abuse TREATMENT when determining whether BENEFITS for alcoholism and drug abuse TREATMENT remain available.

j. Professional licensed ambulance SERVICE when necessary to transport a PARTICIPANT to or from a HOSPITAL but limited to $50.00 per trip. SERVICES include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance SERVICE is unavailable and such transportation is substantiated by a PHYSICIAN as being MEDICALLY NECESSARY.

k. TREATMENT of Temporomandibular Disorders. BENEFITS are payable for diagnostic procedures and surgical or non-surgical TREATMENT for the correction of temporomandibular disorders, if all of the following apply:

(1) a CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

(2) 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.

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

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

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

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

(2) routine taking and reading of pap smear or routine papanicolaou smear;

(3) mammograms, pap smears and PSA tests provided in connection with an ILLNESS.

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

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

o. BENEFITS are payable for Intrauterine devices (IUD); diaphragms, and injections of medication for birth control, and related HEALTH CARE SERVICES. Subdermal contraceptive implants (Norplant) are not covered.

4. Major Medical Coverage.

Except as excluded in Sections VIII., IX., and XII., BENEFITS are payable for CHARGES for HEALTH CARE SERVICES listed in this paragraph 4. that are not paid or payable elsewhere under this Section VI.

a. **Deductible**. The major medical DEDUCTIBLE is the first $250.00 per PARTICIPANT, not to exceed $500.00 per family ($150.00 per PARTICIPANT, not to exceed $300 per family for MEDICARE PARTICIPANTS) of CHARGES for HEALTH CARE SERVICES listed in this Section incurred by a PARTICIPANT during each CALENDAR YEAR.

If any portion of the DEDUCTIBLE is incurred during the last three months of a CALENDAR YEAR, that portion will be applied toward the PARTICIPANT'S DEDUCTIBLE for the next CALENDAR YEAR.

b. **PARTICIPANT Lifetime Maximum Benefit Limit.** The PARTICIPANT lifetime maximum BENEFIT limit for all covered major medical CHARGES for each PARTICIPANT is $250,000.00.

The PARTICIPANT lifetime maximum BENEFIT limit applies to all covered major medical expenses incurred during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under this CONTRACT. However, after a

PARTICIPANT has received major medical BENEFITS of $30,000.00, the remaining portion of the PARTICIPANT lifetime maximum BENEFIT limit will be increased the beginning of each succeeding CALENDAR YEAR by the lesser of $10,000.00 or the amount necessary to restore the PARTICIPANT lifetime maximum BENEFIT limit to $250,000.00.

c. **Major Medical BENEFITS.** BENEFITS are payable for CHARGES for the following major medical SERVICES if the SERVICES are received after the PARTICIPANT'S EFFECTIVE DATE under this CONTRACT and are MEDICALLY NECESSARY for the admission, diagnosis and TREATMENT of the PARTICIPANT, as determined by WPS.

BENEFITS are payable at 80% of the following CHARGES per CALENDAR YEAR.

After the COINSURANCE amount reaches $1,000.00 for any PARTICIPANT with a maximum of $2,000.00 for any FAMILY PARTICIPANT during that CALENDAR YEAR, BENEFITS under this paragraph 4. shall be provided at 100% of the CHARGES incurred during the remainder of that CALENDAR YEAR.

(1) HOSPITAL SERVICES as described in Section B. 1. above, except payment for INPATIENT SERVICES for alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS are excluded (See Section B. 1. b. through e. for INPATIENT Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS BENEFITS).

(2) PROFESSIONAL SERVICES, including psychiatric therapy SERVICES to INPATIENTS**.**

(3) Physical examinations, including routine physical examinations performed and billed by a PHYSICIAN. Physical examinations requested by a third party are not covered under this CONTRACT.

(4) Physical, speech, occupational, respiratory and aquatic therapy prescribed by a PHYSICIAN when necessitated by an ILLNESS or INJURY by a PHYSICIAN, registered physical, speech, occupational or respiratory therapist or any other provider approved by WPS other than one who ordinarily resides in the PARTICIPANT'S home or who is a member of the PARTICIPANT'S IMMEDIATE FAMILY.

(5) Special duty nursing by a registered or licensed practical nurse other than one who ordinarily resides in the PARTICIPANT'S home or who is a member of the PARTICIPANT'S family and prescribed by a PHYSICIAN.

(6) Total extraction or total replacement of natural teeth by a PHYSICIAN when necessitated by an INJURY. A dental repair method, other than extraction and replacement, may be considered if approved by WPS before the SERVICE is performed. This includes dentures but does not include dental implants.

(7) Professional licensed ambulance SERVICE necessary to transport a PARTICIPANT to or from a HOSPITAL. SERVICES include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance SERVICE is unavailable and such transportation is substantiated by a PHYSICIAN as being MEDICALLY NECESSARY.

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

(a) Blood or blood plasma;

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

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

(d) oxygen; and

(e) Rental of radium and radioactive isotopes.

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

(10) OUTPATIENT cardiac rehabilitation SERVICES. SERVICES must be approved by WPS and provided in an OUTPATIENT department of a HOSPITAL, in a medical center or clinic program. This BENEFIT applies only to PARTICIPANTS with a recent history of: (a) a heart attack (myocardial infarction); (b) coronary bypass surgery; (c) onset of angina pectoris; (d) heart valve surgery; (e) onset of decubital angina; (f) onset of unstable angina; (g) percutaneous transluminal angioplasty; or (h) any other condition for which WPS determines cardiac rehabilitation as being appropriate for treating a PARTICIPANT'S medical condition.

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

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

(11) BENEFITS are payable for CHARGES for home attendance and care recommended by the attending physician and provided by other than a registered or licensed practical nurse or a member of the PARTICIPANT'S family. The maximum BENEFIT limit is 150 days at $10.00 per day during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the CONTRACT.

(12) CHARGES for BIOLOGICALS and prescription drugs required to be administered during an office visit with a PHYSICIAN for TREATMENT of an ILLNESS or INJURY.

(13) CHARGES for the installation and use of an insulin infusion pump, and all other equipment and supplies, excluding insulin and disposable diabetic supplies, used in the TREATMENT of diabetes. This benefit is limited to the purchase of one pump per PARTICIPANT per CALENDAR YEAR. The PARTICIPANT must use the pump for at least 30 days before the pump is purchased. BENEFITS are also payable for CHARGES for diabetic self-management education programs.

(14) CHARGES for immunizations including, but not limited to, the following: diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; prevnar, and varicella. Immunizations for travel purposes are not covered. The annual DEDUCTIBLE and COINSURANCE amounts do not apply to immunizations provided to PARTICIPANTS to age six.

C. DEDUCTIBLE STANDARD PLAN BENEFITS

The benefits described in Section VI. B., are modified as follows for the DEDUCTIBLE Standard Plan.

1. The following limitations apply to all HEALTH CARE SERVICES that are covered **BENEFITS for Non-MEDICARE and MEDICARE PARTICIPANTS.**

a. **DEDUCTIBLE.** The annual DEDUCTIBLE amount is $500 per PARTICIPANT, not to exceed $1,000 per family per CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No BENEFITS are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The deductible amounts do not apply to the treatment of alcoholism, drug abuse and nervous and mental disorders.

If any portion of the DEDUCTIBLE is incurred during the last three months of a CALENDAR YEAR, that portion will be applied toward the PARTICIPANT'S DEDUCTIBLE for the next CALENDAR YEAR.

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

b. **COINSURANCE.** After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expense for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER at 80% (100% for MEDICARE PARTICIPANTS), except as specifically stated otherwise in the PLAN, up to the annual out-of-pocket stated below.

c. **ANNUAL OUT-OF-POCKET LIMIT.** The annual OUT-OF-POCKET limit is $2,000 per PARTICIPANT ($500 per MEDICARE PARTICIPANT), not to exceed $4,000 per family ($1,000 for MEDICARE PARTICIPANTS). This total is made up of the DEDUCTIBLE and COINSURANCE amounts a PARTICIPANT pays for covered expenses in one CALENDAR YEAR. No benefits are payable for CHARGES used to satisfy a PARTICIPANT'S annual DEDUCTIBLE amount and COINSURANCE amounts. After the annual OUT-OF-POCKET limit is satisfied, BENEFITS are payable at 100% of the CHARGES for covered expenses unless specifically stated otherwise in this section, incurred by a PARTICIPANT during the remainder of the CALENDAR YEAR, subject to the PARTICIPANT'S lifetime maximum benefit limit.

BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall continue to be payable as specifically stated elsewhere in the PLAN.

d. **Lifetime Maximum Limit.** The PARTICIPANT lifetime maximum BENEFIT limit is the total amount of BENEFITS payable for all covered ILLNESSES and INJURIES for

each PARTICIPANT and is $2,000,000. The PARTICIPANT lifetime maximum BENEFIT limit applies to all covered expenses incurred during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the PLAN. No benefits are payable for expenses incurred for HEALTH CARE SERVICES provided to a PARTICIPANT either before that PARTICIPANT'S EFFECTIVE DATE of coverage under the PLAN or after that PARTICIPANT'S coverage has terminated under the PLAN. In no event will the PLAN pay more than the PARTICIPANT lifetime maximum BENEFIT limit.

2. The following paragraph is added to the beginning of subsection VI. B.:

BENEFITS for CHARGES for covered CONFINEMENTS are subject to: (1) preadmission and continued stay certification requirements; and (2) the reductions in benefits shown in Section X. for failure to comply with the certification requirements. Please see Section X. Value Care Program.

3. Paragraph 3. j. of Section VI. B. is deleted.

4. Paragraph 4. a., 4. b. of Section VI. B. and the first two paragraphs of 4. c. of Section VI. B. are deleted.

5. Paragraph 4. d. (7) of Section VI. B. is deleted and replaced by the following:

(7) Professional licensed ambulance SERVICE necessary to transport a PARTICIPANT to or from a HOSPITAL subject to the DEDUCTIBLE and COINSURANCE. SERVICES include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance SERVICE is unavailable and such transportation is substantiated by a PHYSICIAN as being MEDICALLY NECESSARY.

D. STANDARD PREFERRED PROVIDER PLAN (PPP)

The benefits described in Section VI. B., are modified as follows for the Standard Preferred Provider Plan:

1. The following limitations apply to all HEALTH CARE SERVICES that are covered BENEFITS for PARTICIPANTS.

a. DEDUCTIBLE.

(1) Annual DEDUCTIBLE Amount for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER. The annual DEDUCTIBLE amount is $250.00 per PARTICIPANT ($150.00 for MEDICARE PARTICIPANTS), not to exceed $500.00 per family ($300.00 for MEDICARE PARTICIPANTS). The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated in paragraph (2) will NOT be used to satisfy this annual DEDUCTIBLE amount. The annual deductible amounts do not apply to the treatment of alcoholism, drug abuse and nervous or mental disorders.

(2) Annual DEDUCTIBLE Amount for HEALTH CARE SERVICES Provided by a HEALTH CARE PROVIDER Other Than a PREFERRED PROVIDER. The annual DEDUCTIBLE amount is $500.00 per PARTICIPANT ($300.00 for MEDICARE PARTICIPANTS), not to exceed $1,000.00 per family ($600.00 for MEDICARE PARTICIPANTS). The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated in paragraph (1) will NOT be used to satisfy this annual DEDUCTIBLE amount. The annual deductible amounts do not apply to the treatment of alcoholism, drug abuse and nervous or mental disorders.

If any portion of the DEDUCTIBLE stated in (1) and (2) above is incurred during the last three months of a CALENDAR YEAR that portion will be applied toward the PARTICIPANT'S DEDUCTIBLE for the next CALENDAR YEAR.

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

b. COINSURANCE.

(1) COINSURANCE for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER. After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER at 90% (100% for MEDICARE PARTICIPANTS), unless specifically stated otherwise in the PLAN, up to the annual out-of-pocket limit stated below.

(2) COINSURANCE for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a HEALTH CARE PROVIDER Other Than a PREFERRED PROVIDER. After the DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER at 70% (100% for MEDICARE PARTICIPANTS), unless specifically stated otherwise in the PLAN, up to the annual out-of-pocket limit stated below.

(3) COINSURANCE for Independent Anesthesiologists. After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 90% (100% for MEDICARE PARTICIPANTS) of the CHARGES for HEALTH CARE SERVICES provided and billed by an independent anesthesiologist, unless specifically stated otherwise in the PLAN.

(4) COINSURANCE for Radiology, Pathology and Laboratory Services. After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 90% (100% for MEDICARE PARTICIPANTS) of the CHARGES for radiology, pathology and laboratory services for TREATMENT of an ILLNESS or INJURY and for routine SERVICES. This includes x-rays, laboratory services, allergy testing, MRI's, CT scans, pap smears and mammograms.

(5) **COINSURANCE for HOSPITAL Emergency Room Visits.** After the preferred annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 90% (100% for MEDICARE PARTICIPANTS) of the CHARGES for the emergency room fee billed by the HOSPITAL for use of the HOSPITAL emergency room, PHYSICIAN'S PROFESSIONAL SEVICES and MISCELLANEOUS HOSPITAL EXPENSES for HEALTH CARE SERVICES provided during the visit to the HOSPITAL emergency room.

c. Annual Out of Pocket Limit.

(1) **Annual Out-of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER.** The annual out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER is $1,000.00 ($150.00 for MEDICARE PARTICIPANTS) per PARTICIPANT, not to exceed $2,000.00 ($300.00 for MEDICARE PARTICIPANTS) per family. This total is made up of the annual DEDUCTIBLE and COINSURANCE amounts for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph (2) below will NOT be used to satisfy this annual out-of-pocket limit.

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

After the applicable annual out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in the PLAN, incurred by the PARTICIPANT during the remainder of the CALENDAR YEAR, subject to the lifetime maximum benefit limit and all other terms, conditions and provisions of the PLAN. This paragraph does not apply to BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS. BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall continue to be payable as specifically stated elsewhere in the PLAN.

(2) **Annual Out-Of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a HEALTH CARE PROVIDER Other Than a PREFERRED PROVIDER.** The annual out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER is $2,000.00 per PARTICIPANT ($300.00 for MEDICARE PARTICIPANTS), not to exceed $4,000.00 per family ($600.00 for MEDICARE PARTICIPANTS). This total is made up of the annual DEDUCTIBLE and COINSURANCE amounts for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph (1) above will NOT be used to satisfy this annual out-of-pocket limit.

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

CHARGES used to satisfy the appropriate DEDUCTIBLE and COINSURANCE amounts.

After the applicable annual out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in the PLAN, incurred by the PARTICIPANT during the remainder of the CALENDAR YEAR, subject to the lifetime maximum benefit limit and all other terms, conditions and provisions of the PLAN. This paragraph does not apply to BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS. BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall continue to be payable as specifically stated elsewhere in the PLAN.

d. **Lifetime Maximum Limit.** The PARTICIPANT lifetime maximum BENEFIT limit is the total amount of BENEFITS payable for all covered ILLNESSES and INJURIES for each PARTICIPANT and is $2,000,000. The PARTICIPANT lifetime maximum BENEFIT limit applies to all covered expenses incurred during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the PLAN. No benefits are payable for expenses incurred for HEALTH CARE SERVICES provided to a PARTICIPANT either before that PARTICIPANT'S EFFECTIVE DATE of coverage under the PLAN or after that PARTICIPANT'S coverage has terminated under the PLAN. In no event will the PLAN pay more than the PARTICIPANT lifetime maximum BENEFIT limit.

2. The following paragraph is added to the beginning of subsection VI. B.:

BENEFITS for CHARGES for covered CONFINEMENTS are subject to: (1) preadmission and continued stay certification requirements; and (2) the reductions in benefits shown in Section X. for failure to comply with the certification requirements. Please see Section X. Value Care Program

3. The first paragraph of 3. a. (1) is deleted and replaced by the following:

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

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

BENEFITS are payable only if:

4. Paragraph 3. j. of Section VI. B. is deleted.

5. Paragraph 4. a., 4. b. of Section VI. B. and the first two paragraphs of 4. c. of Section VI. B. are deleted.

6. Paragraph 4. d. (7) of Section VI. B. is deleted and replaced by the following:

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

E. DEDUCTIBLE STANDARD PREFERRED PROVIDER PLAN (PPP)

The benefits described in Section VI. B., are modified as follows for the Deductible Standard PREFERRED PROVIDER PLAN.

1. The following limitations apply to all HEALTH CARE SERVICES that are covered BENEFITS for PARTICIPANTS.

a. DEDUCTIBLE.

(1) Annual DEDUCTIBLE Amount for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER. The annual DEDUCTIBLE amount is $500.00 per PARTICIPANT, not to exceed $1,000.00 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated in paragraph (2) will NOT be used to satisfy this annual DEDUCTIBLE amount. The annual deductible amounts do not apply to the treatment of alcoholism, drug abuse and nervous or mental disorders.

(2) Annual DEDUCTIBLE Amount for HEALTH CARE SERVICES Provided by a HEALTH CARE PROVIDER Other Than a PREFERRED PROVIDER. The annual DEDUCTIBLE amount is $1,000.00 per PARTICIPANT, not to exceed $2,000.00 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated in paragraph (1) will NOT be used to satisfy this annual DEDUCTIBLE amount. The annual deductible amounts do not apply to the treatment of alcoholism, drug abuse and nervous or mental disorders.

If any portion of the DEDUCTIBLE stated in (1) and (2) above is incurred during the last three months of a CALENDAR YEAR that portion will be applied toward the PARTICIPANT'S DEDUCTIBLE for the next CALENDAR YEAR.

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

b. COINSURANCE

(1) COINSURANCE for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER. After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER at

80% (100% for MEDICARE PARTICIPANTS), unless specifically stated otherwise in the PLAN, up to the annual out-of-pocket limit stated below.

(2) **COINSURANCE for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a HEALTH CARE PROVIDER Other Than a PREFERRED PROVIDER.** After the DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER at 70% (100% for MEDICARE PARTICIPANTS), unless specifically stated otherwise in the PLAN, up to the annual out-of-pocket limit stated below.

(3) **COINSURANCE for Independent Anesthesiologists.** After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 80% (100% for MEDICARE PARTICIPANTS) of the CHARGES for HEALTH CARE SERVICES provided and billed by an independent anesthesiologist, unless specifically stated otherwise in the PLAN.

(4) **COINSURANCE for Radiology, Pathology and Laboratory Services.** After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 80% (100% for MEDICARE PARTICIPANTS) of the CHARGES for radiology, pathology and laboratory services for treatment of an ILLNESS or INJURY and routine SERVICES. This includes x-rays, laboratory services, allergy testing, MRI's, CT scans, pap smears and mammograms.

(5) **COINSURANCE for HOSPITAL Emergency Room Visits.** After the preferred annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 80% (100% for MEDICARE PARTICIPANTS) of the CHARGES for the emergency room fee billed by the HOSPITAL for use of the HOSPITAL emergency room, PHYSICIAN'S PROFESSIONAL SEVICES and MISCELLANEOUS HOSPITAL EXPENSES for HEALTH CARE SERVICES provided during the visit to the HOSPITAL emergency room.

c. Annual Out-of-Pocket Limit

(1) **Annual Out-of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER.** The annual out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER is $2,000.00 ($500.00 for MEDICARE PARTICIPANTS) per PARTICIPANT, not to exceed $4,000.00 ($1,000.00 for MEDICARE PARTICIPANTS) per family. This total is made up of the annual DEDUCTIBLE and COINSURANCE amount for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph (2) below will NOT be used to satisfy this annual out-of-pocket limit.

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

After the applicable annual out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in the PLAN, incurred by the PARTICIPANT during the remainder of the CALENDAR YEAR, subject to the lifetime maximum benefit limit and all other terms, conditions and provisions of the PLAN. This paragraph does not apply to BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS. BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall continue to be payable as specifically stated elsewhere in the PLAN.

(2) **Annual Out-Of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a HEALTH CARE PROVIDER Other Than a PREFERRED PROVIDER.** The annual out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER is $4,000.00 per PARTICIPANT ($1,000.00 for MEDICARE PARTICIPANTS), not to exceed $8,000.00 per family ($2,000.00 for MEDICARE PARTICIPANTS). This total is made up of the annual DEDUCTIBLE and COINSURANCE amount for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a HEALTH CARE PROVIDER other than a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph (1) above will NOT be used to satisfy this annual out-of-pocket limit.

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

After the applicable annual out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in the PLAN, incurred by the PARTICIPANT during the remainder of the CALENDAR YEAR, subject to the lifetime maximum benefit limit and all other terms, conditions and provisions of the PLAN. This paragraph does not apply to BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS. BENEFITS for treatment of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS shall continue to be payable as specifically stated elsewhere in the PLAN.

d. **Lifetime Maximum Benefit Limit.** The PARTICIPANT lifetime maximum BENEFIT limit is the total amount of BENEFITS payable for all covered ILLNESSES and INJURIES for each PARTICIPANT and is $2,000,000. The PARTICIPANT lifetime maximum BENEFIT limit applies to all covered expenses incurred during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the PLAN. No benefits are payable for expenses incurred for HEALTH CARE SERVICES provided to a PARTICIPANT either before that PARTICIPANT'S EFFECTIVE DATE of coverage under the PLAN or after that PARTICIPANT'S coverage has terminated under the PLAN. In no event will the PLAN pay more than the PARTICIPANT lifetime maximum BENEFIT limit.

2. The following paragraph is added to the beginning of subsection VI. B.:

BENEFITS for CHARGES for covered CONFINEMENTS are subject to: (1) preadmission and continued stay certification requirements; and (2) the reductions in benefits shown in Section X. for failure to comply with the certification requirements. Please see Section X. Value Care Program.

3. The first paragraph of 3. a. (1) is deleted and replaced by the following:

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

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

BENEFITS are payable only if:

4. Paragraph 3. j. of Section VI. B. is deleted.

5. Paragraph 4. a., 4. b. of Section VI. B. and the first two paragraphs of 4. c. of Section VI. B. are deleted.

6. Paragraph 4. d. (7) of Section VI. B. is deleted and replaced by the following:

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

F. STATE MAINTENANCE PLAN.

This section applies to WISCONSIN PUBLIC EMPLOYERS EMPLOYEES and their eligible DEPENDENTS who have elected the State Maintenance Plan (SMP).

If the PARTICIPANT does not reside in a county listing a PRIMARY PHYSICIAN for the SUBSCRIBER'S PLAN at the time continuation coverage is elected, the PARTICIPANT may elect a participating PLAN in the county where the PARTICIPANT resides.

The benefits described in Section VI. B., are modified as follows for the SMP PLAN.

1. For the purpose of this Section VI F., only, the following terms are in addition to, or a substitute for, the terms defined in Section I.

PRIMARY PHYSICIAN means the same as SELECTED SMP PHYSICIAN as defined below.

REFER/REFERRAL means when a SMP PHYSICIAN sends a PARTICIPANT to another HEALTH CARE PROVIDER who is not a SMP PROVIDER for HEALTH CARE SERVICES to treat a covered ILLNESS or INJURY. The REFERRAL must be: (a) requested by a PARTICIPANT'S SMP PROVIDER; (b) received by WPS in writing or by telephone prior to the PARTICIPANT'S receipt of the HEALTH CARE SERVICES; (c) for HEALTH CARE SERVICES that are not otherwise available from a SMP PROVIDER; (d) approved in writing by WPS in advance of the SERVICE; and (e) valid for the period of time specified by WPS.

SELECTED SMP PHYSICIAN means a SMP PROVIDER selected by a PARTICIPANT to manage the health maintenance of a PARTICIPANT, if the SMP PROVIDER agrees to manage the health maintenance of the PARTICIPANT. The SELECTED SMP PHYSICIAN must:

a. manage a PARTICIPANT'S health maintenance;

b. provide PROFESSIONAL SERVICES;

c. prescribe other health care SERVICES and supplies personally or by REFERRAL to other PHYSICIANS or to paramedical personnel.

SMP PROVIDER means a PHYSICIAN, or a group of PHYSICIANS, associated through group practice, clinics or similar arrangements; HOSPITAL or other PROVIDER; who has an agreement in force with WPS to participate in the SMP for the purpose of providing, prescribing or directing HEALTH CARE SERVICES to or for PARTICIPANTS. A list of SMP PROVIDERS who provide such care will be provided by WPS to those who are eligible to participate in the SMP.

URGENT CARE means for an accident or illness which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs and the PARTICIPANT cannot reach a SMP PROVIDER, 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 a SMP PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT receives such care from a SMP PROVIDER.

2. The following eligibility provisions are added as follows:

a. PARTICIPANTS under the age of 65 and/or not eligible for MEDICARE as the primary payor are eligible to participate in the SMP on the date they become PARTICIPANTS.

b. The requirement that a PARTICIPANT must be under age 65 and/or not eligible for MEDICARE is deferred until the PARTICIPANT'S termination of employment with their Wisconsin Public Employer.

c. A PARTICIPANT whose participation in the SMP terminates because of MEDICARE eligibility automatically becomes a PARTICIPANT in the STANDARD PLAN as described in this article.

d. The BOARD will determine geographical areas where the SMP may be offered.

3. The following BENEFIT provisions are added or changed:

Except as excluded in Sections VIII., IX., and XII., PARTICIPANTS who have been specified by the BOARD to WPS for enrollment in the SMP will on or after the EFFECTIVE DATE be entitled to the BENEFITS as described in Section VI. and this paragraph 3.

a. The first paragraph of Section VI. B. is deleted and replaced by the following:

BENEFITS are payable for CHARGES for covered expenses a PARTICIPANT incurs in connection with a covered ILLNESS or INJURY or specific routine/preventive SERVICES as stated in this section when provided by a SMP PROVIDER. Covered expenses must be incurred while the PARTICIPANT is covered under the PLAN. BENEFITS are not payable for MAINTENANCE THERAPY, CUSTODIAL CARE, SUPPORTIVE CARE, or any HEALTH CARE SERVICE to which an exclusion applies.

HEALTH CARE SERVICES provided by a HEALTH CARE PROVIDER other than a SMP PROVIDER are only payable if such SERVICES were: (1) provided by a PHYSICIAN to whom the PARTICIPANT was REFERRED by the SMP PROVIDER; or (2) provided in connection with EMERGENCY MEDICAL CARE.

URGENT CARE is not EMERGENCY MEDICAL CARE. It does not include care that can safely postponed until the PARTICIPANT receives such care from a SMP PROVIDER.

A PARTICIPANT should receive URGENT CARE from a SMP PROVIDER. If the PARTICIPANT cannot reach a SMP PROVIDER, he/she should go to the nearest appropriate medical facility unless he/she can safely receive care from a SMP PROVIDER. Non urgent follow up care must be received from an SMP PROVIDER unless it is authorized by WPS.

b. Section VI. B. 1. d. (2) is deleted and replaced by the following:

(2) **CONFINEMENT in a SPECIALTY HOSPITAL.** This applies to those PARTICIPANTS admitted as resident patients in a SPECIALTY HOSPITAL for TREATMENT of alcoholism and drug abuse.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred for up to 365 days per CALENDAR YEAR. This BENEFIT limit will be reduced by any BENEFITS payable under subsection B. 1. b., above.

(a) CHARGES for room and board for occupancy of semiprivate or lesser accommodations. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(b) CHARGES for nursing services; and

(c) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES.

c. Section VI. B. 4, a. is deleted and replaced by the following:

a. **Deductible.** The major medical DEDUCTIBLE is the first $200.00 per PARTICIPANT, not to exceed $400.00 per family of CHARGES for HEALTH CARE SERVICES listed in this section incurred by a PARTICIPANT during each CALENDAR YEAR. This deductible does not apply to PROFESSIONAL SERVICES and physical examinations described in Section VI. B. 4. c. (2) and (3).

If any portion of the DEDUCTIBLE is incurred during the last three months of a CALENDAR YEAR, that portion will be applied toward the PARTICIPANT'S DEDUCTIBLE for the next CALENDAR YEAR.

d. The second paragraph in Section VI. B. 4. c. is deleted and replaced by the following:

BENEFITS are payable at 80% of the following CHARGES per CALENDAR YEAR, except as specifically stated below.

e. Section VI. B. 4. c. (2) and (3) are deleted and replaced by the following:

(2) PROFESSIONAL SERVICES, including psychiatric therapy SERVICES to INPATIENTS. BENEFITS are payable at 100% of the charges for these PROFESSIONAL SERVICES.

(3) Physical examinations, including routine physical examinations performed and billed by a PHYSICIAN. BENEFITS are payable at 100% of the charges for such physical examinations. Physical examinations requested by a third party are not covered under this CONTRACT.

f. Section VI. B. 4. c. (15) is added as follows:

(15) BENEFITS are payable for CHARGES without a REFERRAL for the following additional HEALTH CARE SERVICES provided or prescribed by a SMP PROVIDER, licensed optometrist or dentist:

(a) **Preventive Dental Care SERVICES.** Each PARTICIPANT who is under age 12 will be entitled to receive preventive dental care limited to routine oral examination, prophylaxis (scaling and cleaning of teeth) and topical fluoride TREATMENT, but not more than once in any 180 consecutive day period.

(b) **Preventive Vision Care SERVICES.** Each PARTICIPANT who is under age 18 will be entitled to receive preventive vision care limited to:

i. vision analysis (eye examination), but not more than once in any period of 365 consecutive days. Vision analysis includes, but is not limited to, case history, ocular health examination, refraction, gross visual fields and ocular/visual sensory motor function.

ii. CHARGES for eye refractions. .

(c) **Second Surgical Opinion SERVICES.** CHARGES are payable for a second surgical opinion from any PHYSICIAN for any elective surgical procedure, if the second PHYSICIAN is not an associate, partner or relative of the PHYSICIAN who provided the first surgical opinion and was scheduled to perform the surgery.

G. DEDUCTIBLE SMP – WISCONSIN PUBLIC EMPLOYERS

This Section applies to WISCONSIN PUBLIC EMPLOYERS' EMPLOYEES and their eligible DEPENDENTS who have elected the DEDUCTIBLE SMP.

The benefits described in Section VI. B., are modified as follows for the DEDUCTIBLE SMP PLAN.

1. For the purpose of this Section VI. G., all changes state in Section VI. F. also apply to this Section VI. G.

2. The following limitations apply to all HEALTH CARE SERVICES that are covered BENEFITS.

a. **DEDUCTIBLE.** The annual DEDUCTIBLE amount is $500.00 per PARTICIPANT, not to exceed $1,000.00 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. The annual deductible amounts do not apply to the treatment of alcoholism, drug abuse and nervous or mental disorders.

If any portion of the DEDUCTIBLE is incurred during the last three months of a CALENDAR YEAR, that portion will be applied toward the PARTICIPANT'S DEDUCTIBLE for the next CALENDAR YEAR.

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

b. **COINSURANCE.** After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT at 100%, unless specifically stated otherwise in the PLAN.

c. **Lifetime Maximum.** The PARTICIPANT lifetime maximum BENEFIT limit is the total amount of BENEFITS payable for all covered ILLNESSES and INJURIES for each PARTICIPANT and is $2,000,000. The PARTICIPANT lifetime maximum BENEFIT limit applies to all covered expenses incurred during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the PLAN. No benefits are payable for expenses incurred for HEALTH CARE SERVICES provided to a PARTICIPANT either before that PARTICIPANT'S EFFECTIVE DATE of coverage under the PLAN or after that PARTICIPANT'S coverage has terminated under the PLAN. In no event will the PLAN pay more than the PARTICIPANT lifetime maximum BENEFIT limit.

3. The following paragraph is added to the beginning of subsection VI. B.:

BENEFITS for CHARGES for covered CONFINEMENTS are subject to: (1) preadmission and continued stay certification requirements; and (2) the reductions in benefits shown in Section X. for failure to comply with the certification requirements. Please see Section X. Value Care Program.

VII. MEDICARE PLUS $1,000,000 COVERAGE

For PARTICIPANTS enrolled for MEDICARE PLUS $1,000,000 coverage, this Section VII. applies.

A. DEFINITIONS

For the purpose of this Section VII. only, the following terms when used AND capitalized in this Section, are in addition to, or a substitute for, the terms defined in Section I.

BENEFITS mean payments for HOSPITAL SERVICES, EXTENDED CARE SERVICES, PROFESSIONAL SERVICES and OTHER SERVICES.

EFFECTIVE DATE means the date as certified by the BOARD and shown on the records of WPS on which a PARTICIPANT becomes entitled to BENEFITS specified in this Section VII.

EXTENDED CARE FACILITY means the same as it does under MEDICARE.

EXTENDED CARE SERVICES means those SERVICES defined under MEDICARE and covered by MEDICARE in a MEDICARE certified EXTENDED CARE FACILITY which include: SKILLED NURSING CARE; accommodations provided in connection with the furnishing of SKILLED NURSING CARE; physical, occupational or speech therapy furnished or arranged by the EXTENDED CARE FACILITY; medical social SERVICES; prescription drugs prescribed by a PHYSICIAN and required to be administered by a professional provider and BIOLOGICALS (including whole blood and packed red blood cells) which are determined by WPS to be medically recognized as being used in the TREATMENT of an ILLNESS or INJURY; MEDICAL SUPPLIES, appliances and DURABLE MEDICAL EQUIPMENT used in and furnished by the EXTENDED CARE FACILITY for the care and treatment of INPATIENTS; MEDICAL SERVICES of interns and residents-in-training under an approved teaching program of a HOSPITAL with which the facility has in effect a transfer agreement; and other diagnostic or therapeutic SERVICES and supplies provided by a HOSPITAL with which the EXTENDED CARE FACILITY has in effect a transfer agreement.

PARTICIPANT means a PARTICIPANT, or any of his/her DEPENDENTS, eligible for MEDICARE for whom proper application for MEDICARE PLUS $1,000,000 coverage has been made and for whom the appropriate PREMIUM has been paid.

BENEFIT PERIOD~~SPELL OF ILLNESS~~ means the total duration of all successive CONFINEMENTS that are separated from each other by less than 60 days.

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

B. BENEFITS AVAILABLE

Except as excluded in Sections VIII., IX., XII., and XIV., BENEFITS are payable for CHARGES for the following SERVICES and supplies on or after the EFFECTIVE DATE according to the terms, conditions and provisions of this CONTRACT, if those SERVICES and supplies are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by WPS.

1. INPATIENT HOSPITAL SERVICES.

HOSPITAL SERVICES for other than Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS are payable at 100% of the CHARGES for a maximum of 120 days during any one BENEFIT PERIOD~~SPELL OF ILLNESS~~ less the number of days specified under MEDICARE for INPATIENT HOSPITAL SERVICES.

However, if the PARTICIPANT occupies a private room, CHARGES for ROOM ACCOMMODATIONS are limited to the HOSPITAL'S average regular per diem CHARGES for all of its two bed ROOM ACCOMMODATIONS.

2. Alcoholism, Drug Abuse and NERVOUS and MENTAL DISORDERS.

a. INPATIENT HOSPITAL SERVICES. This paragraph applies to those PARTICIPANTS admitted as resident patients for TREATMENT of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable at 100% after Medicare's payment up to the lesser of the CHARGES for the first 120 days or the first $6,300.00 in CHARGES each CALENDAR YEAR.

HOSPITAL SERVICES are not to exceed 365 days of CONFINEMENT throughout a PARTICIPANT'S lifetime while the PARTICIPANT is covered under this CONTRACT following the EFFECTIVE DATE under this Section VII.

b. OUTPATIENT HOSPITAL SERVICES. TREATMENT of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS for a PARTICIPANT other than as an INPATIENT is limited to the initial Part B DEDUCTIBLE and the amount which combined with the MEDICARE BENEFIT equals 90% of the first $2,000.00 in CHARGES during any CALENDAR YEAR.

Such TREATMENT SERVICES must be provided by a PHYSICIAN, a licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or who is certified by the American Board of Professional Psychology, a facility established and maintained according to rules promulgated under Wis. Stats. § 51.42(7)(b), or a medical clinic or billed by a psychologist under the direction of a PHYSICIAN.

c. TRANSITIONAL TREATMENT ARRANGEMENTS. Transitional TREATMENT is limited to the initial Part B DEDUCTIBLE and the amount which combined with the MEDICARE BENEFIT equals 90% of the first $3,000.00 in CHARGES during any CALENDAR YEAR.

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

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

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

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

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

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

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

WPS will need the following information from the health care provider to help us determine the medical necessity of such program SERVICE;

(1) A summary of the development of the PARTICIPANT'S ILLNESS and previous TREATMENT.

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

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

d. Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS Maximum. Total BENEFITS payable for all TREATMENT of Alcoholism, Drug Abuse and NERVOUS and MENTAL DISORDERS shall not exceed the annual maximum of $7,000.00 per PARTICIPANT per CALENDAR YEAR.

Note: Annual dollar maximums for mental health only SERVICES are suspended.

Annual dollar maximums remain in force for TREATMENT of alcohol and drug abuse. Any BENEFITS paid during the year for mental health SERVICES will be applied toward the annual BENEFIT maximum for alcohol and drug abuse TREATMENT when determining whether BENEFITS for alcohol and drug abuse TREATMENT remain available.

3. OUTPATIENT HOSPITAL SERVICES.

HOSPITAL SERVICES for an OUTPATIENT are payable at 100% of the CHARGES for:

a. first aid emergency care;

b. surgical procedures;

c. x-ray or laboratory examinations; and

d. x-ray, radium and radioactive isotope therapy.

4. EXTENDED CARE SERVICES IN A LICENSED SKILLED NURSING FACILITY.

BENEFITS are payable for CHARGES for INPATIENT EXTENDED CARE SERVICES if:

a. A PARTICIPANT receives care in a MEDICARE approved EXTENDED CARE FACILITY and remains under continuous active medical supervision provided the PARTICIPANT was a HOSPITAL INPATIENT for at least three days prior to CONFINEMENT in an EXTENDED CARE FACILITY for up to a maximum of 120 days per BENEFIT PERIOD; or

b. A PARTICIPANT receives care in a Non-MEDICARE approved EXTENDED CARE FACILITY and remains under continuous active medical supervision;

If transferred 24 hours of release from a HOSPITAL, this CONTRACT will pay the maximum daily rate established for SKILLED NURSING CARE in that facility by the Department of Health and Family Services for purposes of reimbursement under the Medical Assistance Program under Wis. Stats. § 49.45 to 49.47. BENEFITS are payable for such care at that facility up to 30 days per CONFINEMENT. BENEFITS are payable only if the attending PHYSICIAN certifies that the SKILLED NURSING CARE is MEDICALLY NECESSARY. The PHYSICIAN must recertify this every seven days. BENEFITS are not payable for essentially domiciliary or CUSTODIAL CARE, or care which is available to the PARTICIPANT without CHARGE or under a governmental health care program

(other than a program provided under Chapter 49, Wisconsin Statutes). CHARGES for days 31-100 of CONFINEMENT during a ~~SPELL OF ILLNESS~~BENEFIT PERIOD are limited to $50.00 per day. All covered SERVICES thereafter are payable for an additional 20 days of confinement per BENEFIT PERIOD. In no event are benefits payable for more than a maximum of 120 days of confinement per BENEFIT PERIOD. CUSTODIAL CARE as defined is not covered.

If transferred within 14 days following CONFINEMENT of at least three consecutive days in a HOSPITAL, CHARGES for the first 100 days of CONFINEMENT during a ~~SPELL OF ILLNESS~~BENEFIT PERIOD are limited to $50.00 per day. All covered SERVICES thereafter, subject to the maximum benefit of 120 days of confinement per BENEFIT PERIOD. CUSTODIAL CARE as defined is not covered.

5. PROFESSIONAL SERVICES and OTHER SERVICES.

Except as otherwise specifically provided, BENEFITS for CHARGES for PROFESSIONAL SERVICES and OTHER SERVICES are payable at 100% of the CHARGES for:

a. Cataract lenses following cataract surgery.

b. Chemotherapy.

c. INPATIENT private duty skilled nursing SERVICES.

d. ORAL SURGERY SERVICES and associated diagnostic x-rays, but excluding extraction of teeth other than by surgery, root canal procedures, dental implants, filling, capping, recapping or other routine repair or maintenance of teeth. ORAL SURGERY SERVICES include total extraction or total replacement of natural teeth when necessitated by an INJURY. SERVICES must occur while the PARTICIPANT is entitled to BENEFITS. A dental repair method, other than extraction and replacement, may be considered if approved by WPS before the SERVICE is performed.

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

f. Physical, speech and occupational therapy when necessitated by an ILLNESS or INJURY, by a registered physical, speech or occupational therapist other than one whom ordinarily resides in the PARTICIPANT'S home or who is a member of the PARTICIPANT'S family, when recommended by a PHYSICIAN.

g. Oxygen and rental of equipment for its administration.

h. Professional licensed ambulance SERVICE necessary to transport a PARTICIPANT to or from a HOSPITAL. SERVICES include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance SERVICE is unavailable and such transportation is substantiated by a PHYSICIAN as being MEDICALLY NECESSARY.

i. Treatment of Temporomandibular Disorders. Covers diagnostic procedures and prior authorized MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

(1) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

(2) 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.

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

This includes coverage of non-surgical TREATMENT, including intraoral splint therapy, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Benefits for diagnostic procedures and non-surgical treatment will be payable up to $1,250.00 per contract year.

j. MEDICAL SUPPLIES prescribed by a PHYSICIAN. BENEFITS are payable only if WPS approves the supply as being appropriate for a PARTICIPANT'S medical condition.

k. Rental of or, at the option of WPS, purchase of DURABLE MEDICAL EQUIPMENT such as, but not limited to: wheelchairs, hospital type beds and artificial respiration equipment. When the equipment is purchased, BENEFITS are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance and replacement of batteries are not covered.

l. OUTPATIENT cardiac rehabilitation SERVICES. SERVICES must be approved by WPS and provided in an OUTPATIENT department of a HOSPITAL, in a medical center or clinic program. This BENEFIT applies only to PARTICIPANTS with a recent history of:

(1) a heart attack (myocardial infarction);

(2) coronary bypass surgery;

(3) onset of angina pectoris;

(4) heart valve surgery;

(5) onset of decubital angina;

(6) onset of unstable angina; or

(7) percutaneous transluminal angioplasty.

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

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

m. BENEFITS are payable for CHARGES for home attendance and care recommended by the attending PHYSICIAN and provided by other than a registered or licensed practical nurse or a member of the PARTICIPANT'S family. The maximum BENEFIT limit is 150 days at $10.00 per day during the

lifetime of the PARTICIPANT while that PARTICIPANT is covered under the CONTRACT.

n. BENEFITS are payable for CHARGES for initial preventive physical examination. This is defined as PHYSICIAN SERVICES consisting of a physical examination (including measurement of height, weight and blood pressure, and an electrocardiogram) with the goal of health promotion and disease detection; includes education, counseling, and referrals for specified screening SERVICES and other preventive SERVICES. It does not include clinical laboratory tests. Any payable preventative exam must be performed no later than six months after the PARTICIPANT'S initial coverage date in accordance with the requirements under Part B of MEDICARE.

o. Custom molded orthotics prescribed by a physician.

p. immunizations including, but not limited to, the following: diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; and varicella.

6. HOME CARE

a. Covered SERVICES. This paragraph 6. applies only if CHARGES for HOME CARE SERVICES are not covered elsewhere under this CONTRACT. A Department licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the SERVICES. A PARTICIPANT should make sure the agency meets this requirement before SERVICES are provided. BENEFITS are payable for CHARGES for the following SERVICES when MEDICALLY NECESSARY for treatment:

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

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

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

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

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

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

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

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

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

(3) BENEFITS are payable for CHARGES for up to 365 HOME CARE visits in any 12 month period per PARTICIPANT. Each visit by a person providing SERVICES under a HOME CARE plan, evaluating the PARTICIPANT'S need or developing a plan counts as one visit. Each period of up to four straight hours in a 24-hour period of home health aide SERVICE counts as one HOME CARE visit.

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

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

7. Aggregate Lifetime Maximum Benefit Limit.

The aggregate lifetime maximum BENEFIT limit for BENEFITS paid for CHARGES for HEALTH CARE SERVICES covered under this Section VII. is $1,000,000 during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under this CONTRACT.

8. Exclusions.

All exclusions set forth in Section XII. of this CONTRACT apply to this Section VII. In addition, the following SERVICES are excluded from BENEFITS, except as otherwise specifically provided:

a. Immunizations, physical examinations or health checkups.

b. Any ROOM ACCOMMODATIONS, care, SERVICES, equipment, medications, devices, items or supplies if a PARTICIPANT is not entitled to any BENEFITS under MEDICARE.

VIII. TRANSPLANTATIONS, IMPLANTATIONS AND GRAFTING

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

A. BENEFITS

1. TRANSPLANTATIONS.

The following TRANSPLANTATIONS are covered by this CONTRACT:

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

(1) Mydlodysplastic syndrome

(2) Homozygous Beta-Thalassemia

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

(4) Neuroblastoma

(5) Multiple Myeloma, Stage II or Stage III

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

(7) Aplastic anemia;

(8) Acute leukemia;

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

(10) Wiskott - Aldrich syndrome;

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

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

(13) Combined immunodeficiency;

(14) Chronic myelogenous leukemia;

(15) Pediatric tumors based upon individual consideration.

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:

1) Corneal opacity;

2) 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;

3) Corneal ulcer;

4) Repair of severe lacerations.

e. Kidney.

2. IMPLANTATIONS.

The following IMPLANTATIONS are covered by this CONTRACT:

a. Heart valve IMPLANTATION;

b. Pseudophakia (intraocular lens) IMPLANTATION;

c. Penile prosthesis IMPLANTATION;

d. Urethral sphincter IMPLANTATION;

e. Artificial breast IMPLANTATION;

f. pacemaker;

g. defibrillator;

3. GRAFTINGS

The following GRAFTINGS are covered by this CONTRACT:

a. Bone (non-cosmetic);

b. Skin (non-cosmetic);

c. Artery;

d. Arteriovenous shunt;

e. Blood vessel limited to blood vessel repair;

f. Cartilage (non-cosmetic);

g. Conjunctiva;

h. Fascia;

i. Lid margin (non-cosmetic);

j. Mucosa;

k. Bronchoplasty;

l. Coronary bypass;

m. Mucus membrane;

n. Muscle;

o. Nerve;

p. Pterygium;

q. Rectal (Thiersch operation);

r. Sclera;

s. Tendon;

t. Vein (bypass).

B. EXCLUSIONS

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

2. Examples of procedures that are not payable:

a. heart TRANSPLANTATION;

b. intestine TRANSPLANTATION;

c. islet tissue (island of Langerhans-pancreas) TRANSPLANTATION;

d. liver TRANSPLANTATION;

e. lung TRANSPLANTATION;

f. pancreas TRANSPLANTATION;

g. bladder stimulator (pacemaker) IMPLANTATION;

h. implantable or portable artificial kidney or other similar device;

i. dental implants;

j. cochlear implants.

3. All exclusions set forth in Section XII. of this CONTRACT apply to this Section VIII.

IX. COORDINATED HOME CARE, HOME CARE AND HOSPICE CARE SERVICES

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

A. HOME CARE SERVICES

1. Coordinated Home Care.

a. Definitions. The following definitions apply to this paragraph A. 1. only:

HOME CARE means the MEDICALLY NECESSARY care and TREATMENT of a PARTICIPANT in lieu of and as an extension of care in a HOSPITAL under the active supervision of the attending PHYSICIAN, in accordance with an organized coordinated HOME CARE program agreed to and participated in by the PARTICIPANT, the Visiting Nurse Association or a similar not-for-profit or governmental community nursing SERVICE, and the HOSPITAL to which the PARTICIPANT is confined.

PROVIDER means a HOSPITAL, PHYSICIAN or other provider licensed where required and performing within the scope of their license.

b. Eligibility. A PARTICIPANT is eligible for HOME CARE SERVICES only if the following conditions are met:

(1) There is evidence, as determined by WPS, that the PARTICIPANT'S HOSPITAL CONFINEMENT can be substantially reduced by participation in an existing coordinated HOME CARE program serving the area of residence of the PARTICIPANT, provided that the PARTICIPANT does not require psychiatric care, CUSTODIAL CARE or private duty nursing.

(2) The PARTICIPANT'S attending PHYSICIAN certifies that skilled nursing is necessary and sufficient for continued care or TREATMENT of the same ILLNESS or INJURY for which the PARTICIPANT was hospitalized.

(3) The PARTICIPANT consents in writing to be discharged from the HOSPITAL and to accept HOME CARE SERVICES.

(4) The home environment, family relationships and other resources appear adequate to meet the PARTICIPANT'S needs with the help of HOME CARE.

(5) The PARTICIPANT'S placement on the HOME CARE program is arranged by the HOME CARE coordinator prior to the PARTICIPANT'S discharge from the HOSPITAL.

(6) Affirmative proof of CHARGES for HOME CARE SERVICES is furnished to WPS by the coordinating agency.

c. Benefits. Provided that a PARTICIPANT remains home confined, BENEFITS are payable for CHARGES for the following HOME CARE SERVICES provided to the PARTICIPANT:

(1) Home nursing care provided by or under the supervision of a registered nurse of the Visiting Nurse Association or Public Health Nursing Service.

(2) HOSPITAL SERVICES, other than room and board and nursing SERVICES, furnished or provided by the HOSPITAL, under the supervision of the HOSPITAL, either at the OUTPATIENT department of the HOSPITAL or in the PARTICIPANT'S home.

(3) Transportation of the patient to or from the HOSPITAL or PHYSICIAN'S office, as arranged by the HOME CARE coordinator.

d. Limitation. The number of HOME CARE days available is the same as the number of in-HOSPITAL days remaining on the day of HOSPITAL discharge. HOME CARE days do not reduce the number of in-HOSPITAL days available.

e. Exclusions. No BENEFITS are provided for:

(1) any SERVICES not specifically listed above;

(2) SERVICES or supplies not included in the HOME CARE plan established for the patient;

(3) CUSTODIAL CARE and psychiatric care; or

(4) SERVICES excluded in Section XII.

Any BENEFITS available under the mandated HOME CARE BENEFIT will be reduced by any BENEFITS paid under the coordinated HOME CARE, wherever available.

2. Mandated HOME CARE SERVICES.

a. Benefits. This subsection A. 2. applies only if CHARGES for HOME CARE SERVICES are not covered elsewhere under the CONTRACT. A Department licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the SERVICES. A PARTICIPANT should make sure the agency meets this requirement before SERVICES are provided. BENEFITS are payable for CHARGES for the following SERVICES when MEDICALLY NECESSARY for TREATMENT:

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

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

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

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

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

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

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

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

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

(3) BENEFITS are payable for CHARGES for up to 40 HOME CARE visits in any 12 month period per PARTICIPANT. Each visit by a person providing SERVICES under a HOME CARE plan, evaluating the PARTICIPANT'S need or developing a plan counts as one visit. Each period of up to four straight hours in a 24-hour period of home health aide SERVICE counts as one HOME CARE visit.

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

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

3. Home Attendance Care.

BENEFITS are payable for CHARGES for home attendance and care recommended by the attending PHYSICIAN and provided by other than a registered or licensed practical nurse or a member of the PARTICIPANT'S family. The maximum BENEFIT limit is 150 days at $10.00 per day during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under this CONTRACT.

B. HOSPICE CARE SERVICES

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

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

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

c. Physical, respiratory, occupational or speech therapy;

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

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

f. Room and board CHARGES at a WPS approved or MEDICARE certified HOSPICE CARE facility.

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

2. LIMITATIONS FOR HOSPICE CARE SERVICES

BENEFITS for HOSPICE CARE SERVICES are limited as follows:

a. HOSPICE CARE is not covered unless the PARTICIPANT'S attending PHYSICIAN certifies that: (1) hospitalization or CONFINEMENT would otherwise be required; (2) necessary care and TREATMENT are not available from members of the PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT; and (3) the PARTICIPANT is terminally ill with a life expectancy of six months or less.

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

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

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

When BENEFITS are payable under both this HOSPICE CARE BENEFIT and the HOME CARE BENEFIT, BENEFITS payable under this subsection shall reduce any BENEFITS payable under the HOME CARE subsection.

X. VALUE CARE PROGRAM

This Section applies to Sections III., IV., V., VI. C., VI. D., VI. E., and VI. G. Subsection B. and C. of this Section applies to Section VI. B. and Section VI. F. Subsection A. of this Section does not apply to Section VI. B. and Section VI. F.

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

A. PREADMISSION AND CONTINUED STAY CERTIFICATIONS

1. Preadmission Certification.

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

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

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

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

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

(5) the TREATMENT plan for the patient;

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

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

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

(9) the proposed admission date; and

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

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

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

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

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

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

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

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

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

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

Within one business day of WPS' receipt of such information, WPS will notify the PARTICIPANT, PHYSICIAN and HOSPITAL of any change in its original decision.

2. Continued Stay Certification.

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

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

3. Payment of BENEFITS.

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

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

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

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

A PARTICIPANT may receive INPATIENT HOSPITAL SERVICES and related HEALTH CARE SERVICES after WPS originally determines such expenses are not MEDICALLY NECESSARY. A PARTICIPANT may also receive INPATIENT HOSPITAL SERVICES

and related HEALTH CARE SERVICES during HOSPITAL days which exceed the number of HOSPITAL days certified by WPS as being MEDICALLY NECESSARY. Such expenses may later be eligible for BENEFITS under the PLAN if WPS later determines on the basis of new information that such expenses are MEDICALLY NECESSARY for the PARTICIPANT.

B. PRENATAL AND MATERNITY CARE NOTIFICATION

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

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

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

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

C. DISEASE CASE MANAGEMENT

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

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

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

XI. WAITING PERIODS FOR PRE-EXISTING CONDITIONS

This section only applies to Section III., IV., VI., VII., VIII., and IX. for late enrollees only.

Within six months prior to a PARTICIPANT'S enrollment date of coverage under the PLAN, he/she may have: (1) had an ILLNESS or INJURY diagnosed; (2) received care, MEDICAL SERVICES or TREATMENT for an ILLNESS or INJURY; or (3) received medical advice for an ILLNESS or INJURY; or (4) had care, MEDICAL SERVICES or TREATMENT recommended for an ILLNESS or INJURY. If so, BENEFITS are not payable for expenses incurred as a result of that ILLNESS or INJURY and any complications of any such ILLNESS or INJURY until the PARTICIPANT has been covered under the PLAN for 180 days in a row. No BENEFITS are payable for CHARGES for HEALTH CARE SERVICES incurred during the waiting period for any such ILLNESS or INJURY and any complications of any such ILLNESS or INJURY. CHARGES for covered expenses for treatment of a pre-existing ILLNESS or INJURY and any complications of any such ILLNESS or INJURY which are incurred after the expiration of the waiting period for it are eligible for BENEFITS as provided under the PLAN. If a dependent child is born or is legally adopted by a SUBSCRIBER while he/she has FAMILY COVERAGE under the PLAN, the child doesn't have a waiting period for any such ILLNESS or INJURY.

The waiting periods for pre-existing conditions described above do not apply to HEALTH CARE SERVICES in connection with pregnancy.

XII. EXCLUSIONS

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

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

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

C. SERVICES of a blood donor.

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

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

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

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

H. HEALTH CARE SERVICES:

1. that would be furnished to a PARTICIPANT without charge;

2. which a PARTICIPANT would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or

3. which a PARTICIPANT would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical BENEFIT or insurance plan established by any government; if this CONTRACT was not in effect.

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

J. HEALTH CARE SERVICES for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.

K. HEALTH CARE SERVICES furnished by the U.S. Veterans Administration, except for such treatment, SERVICES and supplies for which under this CONTRACT, this CONTRACT is the primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.

L. HEALTH CARE SERVICES available from OTHER COVERAGE. Then, BENEFITS will be limited to the CHARGES for TREATMENT, SERVICES and supplies, less payments available from OTHER COVERAGE. Together, the total BENEFITS payable may not exceed the incurred

CHARGES. In computing allowances available, the primary carrier according to Wis. Adm. Code § 3.40 will provide the full BENEFITS payable under its CONTRACT, with the other carrier processing the remainder of those CHARGES. However, when MEDICARE is primary, payment of BENEFITS is limited to the amount computed without coordination of BENEFITS, less the MEDICARE payments. The MEDICARE allowed amount on assigned claims is considered the CHARGE; on unassigned claims, the CHARGE is the MEDICARE limiting CHARGE amount.

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

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

N. Any BENEFITS under Sections III., IV., V., VI.,VII., VIII.,IX., XI., XII., and XIII. if the PARTICIPANT is eligible to enroll in MEDICARE. This exclusion is not applicable until the PARTICIPANT'S termination of employment with the State of Wisconsin.

O. PROFESSIONAL SERVICES not provided by a PHYSICIAN or any health care provider listed in the definition of PROFESSIONAL SERVICES in Section I. Definitions.

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

Q. If a PARTICIPANT has the SMP, CHARGES for non-emergency or non-INJURY SERVICES and supplies provided or prescribed by a PHYSICIAN or OTHER HEALTH CARE PROVIDER other than a SMP PROVIDER are payable under this CONTRACT only if a written referral pre-approved by WPS to that PHYSICIAN is first obtained.

R. Reversal of sterilization.

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

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

U. 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.

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

W. Food received on an OUTPATIENT basis or food supplements

X. Housekeeping, shopping or meal preparation SERVICES

Y. HEALTH CARE SERVICES in connection with obesity, weight reduction or dietetic control, except for morbid obesity and disease etiology.
All HEALTH CARE SERVICES as described above, including those for morbid obesity and disease etiology are specifically excluded from all State Maintenance Plans (SMP).

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

AA. HEALTH CARE SERVICES used in educational or vocational training or testing.

BB. HEALTH CARE SERVICES in connection with any ILLNESS or INJURY caused by a PARTICIPANT'S: (1) engaging in an illegal occupation; or (2) commission of, or an attempt to commit, a felony.

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

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

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

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

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

HH. HEALTH CARE SERVICES determined to be MAINTENANCE THERAPY by WPS.

II. Over-the-counter drugs.

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

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

LL. Charges for injectable medications, except for self-administered injectable medications and injectable and infusible medications administered during home care, office setting, CONFINEMENT, emergency room visit or urgent care setting.

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

NN. That portion of the amount billed for a HEALTH CARE SERVICE covered under the Plan that exceeds WPS' determination of the CHARGE for such HEALTH CARE SERVICE.

OO. Supportive care.

PP. Telephone, computer or internet consultations between a PARTICIPANT and any HEALTH CARE PROVIDER.

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

XIII. PREAUTHORIZATION

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

A. New medical or biomedical technology;

B. Methods of treatment by diet or exercise;

C. New surgical methods or techniques;

D. Acupuncture or similar methods;

E. Transplants of body organs, unless specifically covered under Section VIII. of this CONTRACT;

F. Sleep studies; and

G. Sclerotherapy.

H. Pain injections such as epidural injections, facet injections or trigger point injections.

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

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

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

XIV. GENERAL CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

O. WPS or a PARTICIPANT'S PHYSICIAN may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment program if it appears that:

1. the recommended TREATMENT offers at least equal medical therapeutic value; and

2. the current TREATMENT program may be changed without jeopardizing the PARTICIPANT'S health; and

3. the CHARGES incurred for SERVICES provided under the recommended TREATMENT will probably be less.

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

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

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

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

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

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

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

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

If any PARTICIPANT has a problem or complaint relating to a BENEFIT determination, he/she should contact WPS. WPS will assist the PARTICIPANT in trying to resolve the matter on an

informal basis, and may initiate a Claim Review of the BENEFIT determination. If the PARTICIPANT wishes, he/she may omit this step and immediately file a formal GRIEVANCE.

R. Claim Review:

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

1. EXPEDITED GRIEVANCE:

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

2. Formal GRIEVANCE:

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

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

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

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

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

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

3. RIGHTS AFTER GRIEVANCE

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

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

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

Department of Employee Trust Funds

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

b. External Review by an Independent Review Organization

ADVERSE DETERMINATIONS involving MEDICAL NECESSITY and EXPERIMENTAL/INVESTIGATIONAL determinations made by WPS may be reviewed by an INDEPENDENT REVIEW ORGANIZATION. WPS will send the PARTICIPANT a list of approved organizations at the time of WPS' written decision regarding the GRIEVANCE. A copy can also be obtained by contacting WPS' Member Service Department or by contacting the Office of the Commissioner Insurance.

To qualify for EXTERNAL REVIEW, the PARTICIPANT'S claim must involve one of the following:

(1) An ADVERSE DETERMINATION involving MEDICAL NECESSITY, or

(2) A determination that a treatment is EXPERIEMENTAL/INVESTIGATION In either case, the treatment must cost more than $282~~274~~.00 in order to qualify for EXTERNAL REVIEW.

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

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

WPS must receive the request within four months of the date of the PARTICIPANT'S GRIEVANCE decision letter. When the PARTICIPANT sends his or her request, the PARTICIPANT must indicate which INDEPENDENT REVIEW ORGANIZATION that he or she wants to use and enclose a $25 check made payable to that organization.

After WPS has received the PARTICIPANT'S request:

(1) WPS will notify the INDEPENDENT REVIEW ORGANIZATION and the Department of Employee Trust Funds within two business days. Within five business days after receiving written notice of a request for independent review, WPS will send the INDEPENDENT REVIEW ORGANIZATION copies of the information the PARTICIPANT submitted as part of his or her GRIEVANCE, copies of the contract, and copies of any other information WPS relied on in the PARTICIPANT'S GRIEVANCE.

(2) The INDEPENDENT REVIEW ORGANIZATION will review the submitted materials and will request, generally within five business days, any additional information.

(3) WPS will respond to any additional requests within five business days, or provide an explanation as to why such information cannot be provided.

(4) Once the INDEPENDENT REVIEW ORGANIZATION has received all the necessary information, it will render a decision, typically within 30 business days.

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

(1) WPS agrees to proceed directly to EXTERNAL REVIEW, or

(2) The PARTICIPANT'S situation requires an EXPEDITED REVIEW.

If the PARTICIPANT'S situation requires an EXPEDITED REVIEW:

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

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

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

(4) If the INDEPENDENT REVIEW ORGANIZATION overturns WPS' decision, the $25 the PARTICIPANT paid when requesting the review will be refunded. The decision of the INDEPENDENT REVIEW ORGANIZATION is binding to both WPS and the PARTICIPANT as per contract. Once the INDEPENDENT REVIEW ORGANIZATION decision is issued, the PARTICIPANT has no further rights to review by the Department of Employee Trust Funds.

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

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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

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

CORRESPONDENCE MEMORANDUM

DATE: May 27, 2008

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson, Quality Assurance Services Bureau
Christina Keeley, Ombudsperson, Quality Assurance Services Bureau
Linda Esser, Executive Staff Assistant, Quality Assurance Services Bureau

SUBJECT: Correspondence and Complaint Summary

This summary is provided for informational purposes and contains a listing of issues raised by participants relating to insurance benefits under the authority of the Group Insurance Board (GIB). The tables below include a summary of the following for the period of March 1, 2008, through April 30, 2008:

(1) correspondence received by the Department addressed to the Secretary or the GIB;

(2) the number of requests for information and assistance made to the ombudspersons in the Quality Assurance Services Bureau (QASB).

QASB staff will be available at the Board meeting to address any questions you have regarding this report. Thank you.

Correspondence:

	Number
Health Insurance	
• Complaint regarding 2007 Dual-Choice and lack of access to providers through Humana Western	**1**
• Complaint regarding WPS retaliatory behavior	**1**
• Complaint regarding Unity Health Plan and misinformation distributed regarding coverage of root canals	**1**
• Request for Employee + 1 coverage plan	**1**
Pharmacy Benefits	
• Complaint that a specific drug (Boniva) is not covered by Navitus	**1**
Disability Programs	
• None	**0**
TOTAL	**5**

Reviewed and approved by Pam Henning, Administrator, Division of Management Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	06/10/2008	6

Contacts to Ombudspersons:

From March 1, 2008, through April 30, 2008, 213 members contacted the ombudspersons for assistance with benefit issues. The majority of these contacts involved health insurance and pharmacy benefits, including inquiries and requests for assistance regarding Medicare Part D. Some reoccurring issues identified by staff included:

- Humana Medicare Advantage Private Fee for Service (PFFS) plan issues including
  - passive enrollment
  - disenrollment problems
  - claims payment problems
  - coupling the PFFS benefit with Uniform Benefits
- Non-coverage of the zoster (shingles) vaccine under Medicare Plus $1,000,000 when the vaccine is covered under Medicare D
- Non-coverage of gastric bypass under Uniform Benefits
- Anthem blue card system problems
- Dental enrollment data problems at Dean (Ameritas) and UnitedHealthcare
- Enrollment data integrity issues between Navitus and Laker (software/data management)

The following tables summarize the method of contact and program areas involved (compared with 2007).

Total Contacts (by month)	2008	2007
March	116	98
April	97	90
Total	213	188

Method of Contact (year to date)	2008	2007
Telephone	415	N/A
E-mail/Contact Us Internet Page	104	N/A
US Mail	21	N/A
Walk-In	10	N/A

Number of Contacts by Program (year to date)	2008	2007
Health Insurance-HMO's	256	180
Health Insurance-Self Funded	125	97
Pharmacy Benefits	104	38
Non WRS Programs (DentalBlue)	23	8
Disability/Income Continuation Insurance	13	6
All Other Program Types* (Life Insurance, ERA, EPIC, Spectera, WRS/ASLCC and WDC)	29	16

*It is not common to receive a large number of complaints regarding these programs. The availability of ombudsperson assistance in this area is not widely known and most of these programs are not under contract with ETF; rather, they are benefits that the Board simply approves to be offered through payroll deduction.

Key:

- *ASLCC: Accumulated Sick Leave Conversion Credit*
- *ERA: Employee Reimbursement Accounts. Optional pre-tax savings account for medical expenses and dependent care.*
- *EPIC: Optional supplemental benefit plan that provides coverage for dental, excess medical and accidental death and dismemberment.*
- *Spectera: Optional vision benefit*
- *WDC: Wisconsin Deferred Compensation*
- *WRS: Wisconsin Retirement System*

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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

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

CORRESPONDENCE MEMORANDUM

DATE: May 27, 2007

TO: Group Insurance Board

FROM: Steve Hurley, Director, Quality Assurance Services Bureau
Christina Keeley, Ombudsperson, Quality Assurance Services Bureau
Liz Doss-Anderson, Ombudsperson, Quality Assurance Services Bureau

SUBJECT: 2007 Health Plan and Pharmacy Benefit Manager Grievance and Independent Review Report

This report on health plan grievances and independent review activity is provided for informational purposes. This information is used to identify trends within the health insurance and pharmacy benefit manager (PBM) programs that warrant attention by the Department. A summary chart will also be included in the Report Card section of the *2009 It's Your Choice* booklet.

I. 2007 Grievance Report for State of Wisconsin and Local Employees

Below is a summary of annual grievance data provided to the Department of Employee Trust Funds (ETF) by all plans participating in the Group Health Insurance Program for State of Wisconsin (State) and Wisconsin Public Employees (WPE). This report includes grievance data for Navitus, which administers pharmacy benefits for all members excluding WPE Medicare-eligible annuitants. WPE Medicare-eligible annuitants are covered under Medicare D and their pharmacy benefit is administered by DeancareRx.

The report was compiled by reviewing each plan's annual grievance report. Grievance reports are submitted to ETF by the plans every March. A grievance is a written request to the plan by, or on behalf of, a member expressing dissatisfaction with a plan decision pertaining to a benefit denial or the provision of services under the contract. Highlights of the data include:

- Health plans reported 1,154 grievances for 2007, compared to 956 in 2006.

  Humana Eastern had the highest percentage of grievances among all health plans participating in the Group Health Insurance Program, with over 21% of all grievances reported, while holding only 6.79% of the total health insurance contracts.

  While grievances increased overall, Navitus Health Solutions has experienced a decrease in grievances each year since the PBM program began in 2004.

Reviewed and approved by Pam Henning, Administrator, Division of Management Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	06/10/2008	6

- In 2007, 662 (57%) of the 1,154 health plan grievances were either partly or fully overturned in favor of the member. Two plans had overturn rates greater than 80%: WPS Patient Choice Plan 2 had only one grievance, which was overturned; Humana had 251 grievances and 215 resulted in compromise or overturn.

  Moderate overturn rates demonstrate the benefit to members of utilizing the plan grievance process. However, very high overturn rates indicate a need for the plan to examine their claims payment policies and processes as well as make a concerted effort to ensure that Uniform Benefits are consistently interpreted and applied. If a plan overturns the majority of the grievances filed, the majority of the claims denied were denied incorrectly.

- The Emergency Room (ER) Services category for Humana Eastern and Humana Western is once again significantly higher than other plans. Humana reported 92 of the 106 emergency room service grievances reported to ETF by all health plans. Historically, Humana has experienced high overturn rates in this category, with 98% overturned in 2006 and 100% overturned in 2007.

  ETF staff and Humana representatives have had several discussions regarding the ER services grievance category. Humana reported a change effective mid-2006 to its ER services claims review process that permitted regional medical directors to authorize payments without sending the matter to formal grievance. However, this change did not subsequently reduce Humana's ER grievance totals. In 2007, Humana reported the mid-year discontinuation of its pend-and-review process for ER service claims coming from the state group. This change did not reduce ER grievances for 2007, but the first quarter of 2008 shows greatly reduced ER grievances. Humana reports that it has had only one ER grievance in the first quarter of 2008. The decrease in ER grievances for the first quarter of 2008 is encouraging. ETF staff will continue to monitor the ER category numbers for the remainder of 2008 and will continue to work with Humana representatives to resolve this matter.

- The total number of PBM grievances for 2007 was 173, down from 248 grievances reported in 2006 and from 315 grievances reported in 2005. The overturn rate for PBM grievances in 2007 was 29%. The majority of PBM grievances related to denials of copayment reductions (37%), followed by denial of non-covered drugs (31.8%).

  The continued decrease in the number of PBM grievances is an encouraging outcome and likely indicates that members are accustomed to the PBM structure and level of benefits. Navitus Health Solutions, has been administering this benefit since its inception in 2004 and has gained proficiency in understanding and consistently applying our benefits. Navitus proactively assists our members in maximizing savings through formulary compliance and use of cost-saving programs, such as mail order and tablet splitting.

- Two plans submitted relatively high numbers of grievances in the “other” category. The total number of grievances reported in this category for all plans was 160. Humana Eastern and Western combined reported 72 “other” and UnitedHealthcare NW and SE combined reported 54. Together Humana and UnitedHealthcare accounted for nearly 80% of all grievances in the “other” category.

ETF discourages plans from using the "other" category unless all other categories are inappropriate. ETF will continue to work with Humana and UnitedHealthcare to address what we consider to be an overuse of this category.

II. 2007 ETF Independent Review Report

This report summarizes independent review (IR) requests by State Group Health Insurance Program members. Members who request IRs must have completed the plan grievance process and may have completed a portion of the administrative review process available within ETF.

To be eligible for a review through an independent review organization (IRO), a member must have an adverse determination (grievance decision) involving a medical judgment wherein the amount at issue is in excess of $274. Typically these are requests for out-of-network referrals or denials of a claim or service that the plan/PBM has deemed to be experimental or not medically necessary. The IR process allows members the opportunity to have an independent consultant review their grievance to determine if benefits are payable. Members must pay a $25 fee to request an IR, and the IRO's decision is binding on both the plan/PBM and the member.

The Quality Assurance Services Bureau is responsible for educating members about the IR process. When the Department processes a new health insurance complaint, it is reviewed by an ombudsperson, and if appropriate, the member is contacted and informed about the advantages and disadvantages of requesting an IR. The Department also monitors health plan grievance decision letters to ensure that members are given their IR rights when applicable.

For 2007, plans reported receiving 20 requests for independent reviews by Group Health Insurance Program members. The outcomes of the reviews were evenly split, with eight resulting in the plan decision being upheld and eight resulting in the plan decision being overturned. Two reviews were declined by the review organization.

Health plans are required to report member requests for IR to ETF at the time the request is made. This year, only 11 of the 20 IR requests made by members were reported timely to ETF by health plans. The balance was reported in the health plans' annual report to ETF. Plans that failed to report IRs to ETF were CompcareBlue, Gundersen Lutheran Health Plan, Health Tradition, Humana, Physicians Plus, UnitedHealthcare and Unity Health Plan. The Quality Assurance Services Bureau addressed this issue with all health plans at the plan meeting held on April 29, 2008.

As in past years, the number of reported IR requests remains low in comparison with the total number of medical necessity or experimental treatment denials made by plans at the grievance level, indicating that only a small percentage of members entitled to an IR elect to take advantage of this option. The Department will continue to work with plans to ensure compliance with the contractual requirement of including IR language with the plan's grievance decision letters and in reporting all IR requests made by our members to ETF.

The attached charts provide detailed grievance data. Percentages in the attached charts are approximate due to rounding. Quality Assurance Services Bureau staff will be available at the meeting to answer questions.

Grievances for State and Local Government Employees - 2005-2007

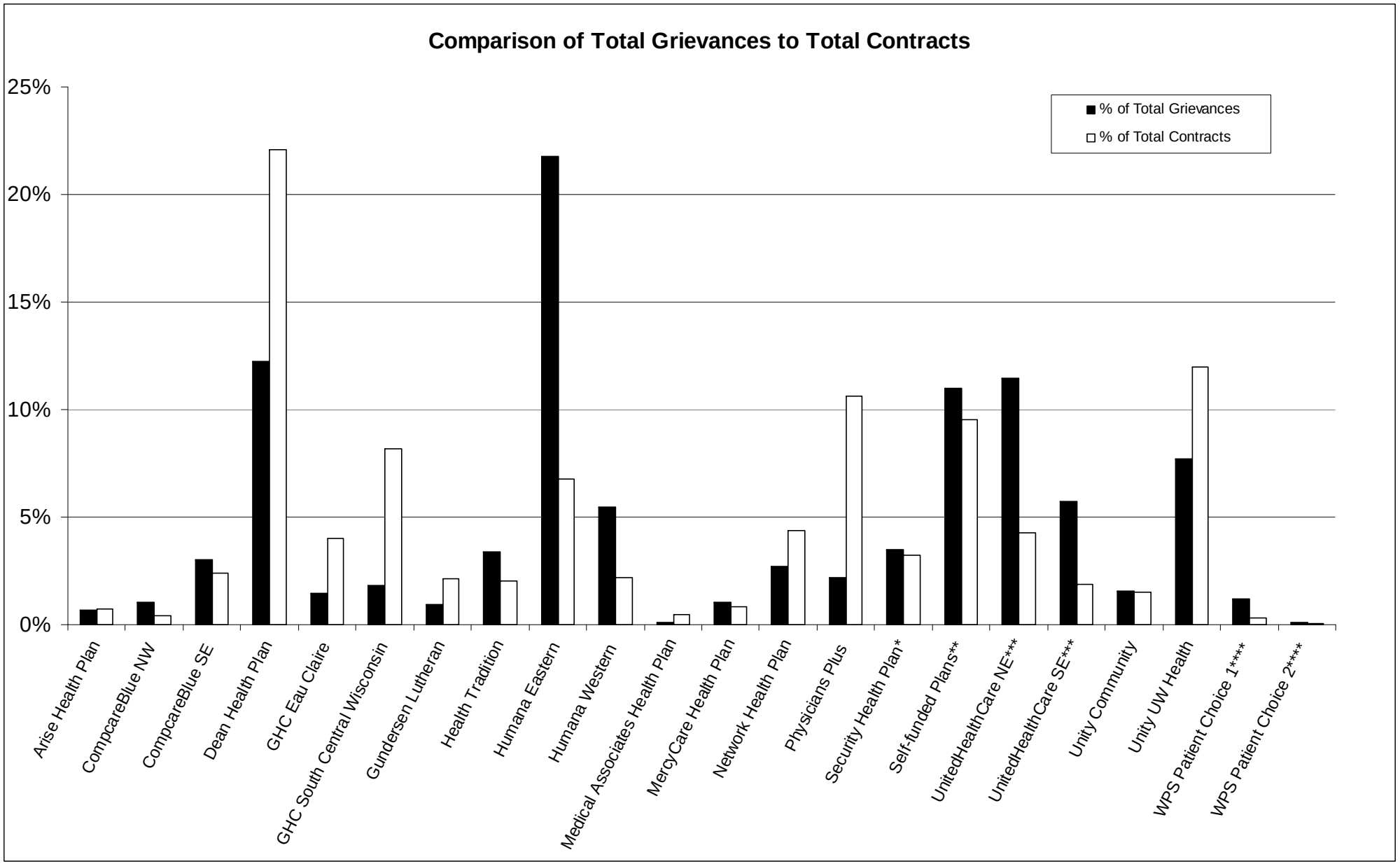
Health Plan Name	Grievances 2005	Grievances 2006	Grievances 2007	Net Change (2006 to 2007)	% of Total Grievances	% of Total Contracts (as of Feb 2007)
Arise Health Plan	23	22	8	-14	0.69%	0.74%
CompcareBlue NW	0	19	12	-7	1.04%	0.44%
CompcareBlue SE	43	16	35	19	3.03%	2.38%
Dean Health Plan	125	143	141	-2	12.22%	22.08%
GHC Eau Claire	0	6	17	11	1.47%	4.02%
GHC South Central Wisconsin	61	34	21	-13	1.82%	8.20%
Gundersen Lutheran	22	14	11	-3	0.95%	2.11%
Health Tradition	20	34	39	5	3.38%	2.01%
Humana Eastern	230	252	251	-1	21.75%	6.79%
Humana Western	92	73	63	-10	5.46%	2.21%
Medical Associates Health Plan	4	7	1	-6	0.09%	0.47%
MercyCare Health Plan	10	7	12	5	1.04%	0.83%
Network Health Plan	32	37	31	-6	2.69%	4.35%
Physicians Plus	30	24	25	1	2.17%	10.61%
Security Health Plan*	NA	NA	40	NA	3.47%	3.22%
Self-funded Plans**	121	57	127	70	11.01%	9.54%
UnitedHealthCare NE***	99	104	132	28	11.44%	4.25%
UnitedHealthCare SE***	NA	23	66	43	5.72%	1.88%
Unity Community	6	7	18	11	1.56%	1.52%
Unity UW Health	32	50	89	39	7.71%	11.98%
WPS Patient Choice 1****	NA	7	14	7	1.21%	0.30%
WPS Patient Choice 2****	NA	3	1	-2	0.09%	0.07%
Grievance Totals (Health)	**927**	**939**	**1,154**	175	100%	100%
Navitus Health Solutions	315	248	173			
Grievance Totals (all)	**1,242**	**1,187**	**1,327**			

**Security Health Plan rejoined the health insurance program in 2007*

*** Self-funded Plans include: Standard Plan; Medicare Plus $1,000,000; Local Annuitant Health Plan; and State Maintenance Plan (administered by WPS Heath Insurance)*

****UnitedHealthcare was one plan in 2005 and split into two regional plans in 2006*

*****WPS Patient Choice 1 and 2 were new to the health insurance program in 2006*



Attachment B

Grievances for State and Local Government Employees – 2007
(Upper chart by Category)
(Lower chart by Outcome)

Grievance Category	Arise Health Plan	CompcareBlue NW	CompcareBlue SE	Dean Health Plan	GHC Eau Claire	GHC SCW	Gundersen Lutheran	Health Tradition	Humana Eastern	Humana Western	Medical Associates	MercyCare Health Plan	Network Health Plan	Physicians Plus	Security Health Plan	Self-funded Plans*	UnitedHealthcare NE	UnitedHealthcare SE	Unity Community	Unity UW Health	WPS Patient Choice 1	WPS Patient Choice 2	Total	% of Total Grievances
Access to Care	0	1	3	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	6	0.5%
Continuity of Care	0	0	0	2	1	0	0	0	4	2	0	0	0	1	0	0	5	5	0	0	0	0	20	1.7%
Drug & Drug Formulary	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0.1%
Emergency Services	0	0	1	2	2	4	0	3	76	16	0	0	0	1	0	1	0	0	0	0	0	0	106	9.2%
Experimental Treatment	0	1	2	3	0	0	0	0	5	1	0	0	0	1	6	14	8	5	0	1	0	0	47	4.1%
Prior Authorization	2	0	0	37	0	2	3	16	45	9	0	8	8	8	9	4	5	6	1	10	0	0	173	15.0%
Non-Covered Benefit	3	2	3	31	6	5	6	7	43	16	1	2	13	12	9	38	10	8	13	54	3	0	285	24.7%
Not Medically Necessary	0	3	11	5	1	1	1	0	6	2	0	0	2	0	0	36	0	0	3	8	1	0	80	6.9%
Other	2	5	10	4	1	1	0	6	57	15	0	1	3	1	0	0	40	14	0	0	0	0	160	13.9%
Plan Administration	0	0	0	4	1	4	0	0	7	1	0	0	0	1	3	25	64	25	0	14	10	1	160	13.9%
Plan Providers	0	0	1	7	5	4	0	0	1	0	0	0	5	0	0	0	0	0	0	0	0	0	23	2.0%
Request for Referral	1	0	4	46	0	0	1	7	6	0	0	1	0	0	13	9	0	3	0	2	0	0	93	8.1%
Total	**8**	**12**	**35**	**141**	**17**	**21**	**11**	**39**	**251**	**63**	**1**	**12**	**31**	**25**	**40**	**127**	**132**	**66**	**18**	**89**	**14**	**1**	**1,154**	100%
% of Total Grievances	**0.7%**	**1.0%**	**3.0%**	**12.2%**	**1.5%**	**1.8%**	**1.0%**	**3.4%**	**21.8%**	**5.5%**	**0.1%**	**1.0%**	**2.7%**	**2.2%**	**3.5%**	**11.0%**	**11.4%**	**5.7%**	**1.6%**	**7.7%**	**1.2%**	**0.1%**	**100%**	

Grievance Outcome																							Total
Approved	3	6	18	68	1	8	5	21	211	46	0	7	19	4	14	51	64	38	11	30	4	1	597
Denied	5	5	13	64	6	13	5	12	36	16	1	5	12	16	22	69	28	14	5	53	8	0	377
Compromise	0	1	3	4	0	0	1	1	4	1	0	0	0	5	3	4	0	0	1	2	2	0	36
Withdrawn	0	0	1	5	10	0	0	5	0	0	0	0	0	0	1	3	40	14	1	4	0	0	82
Total Grievances	**8**	**12**	**35**	**141**	**17**	**21**	**11**	**39**	**251**	**63**	**1**	**12**	**31**	**25**	**40**	**127**	**132**	**66**	**18**	**89**	**14**	**1**	**1,154**
% of Outcomes In Favor of Member**	37.5%	58.3%	60.0%	51.1%	5.9%	38.1%	54.5%	56.4%	85.7%	74.6%	0%	58.3%	61.3%	36.0%	42.5%	43.3%	48.5%	57.6%	66.7%	36.0%	42.9%	100%	**57.4%**

**Self-funded Plans include: Standard Plan; Medicare Plus $1,000,000; Local Annuitant Health Plan; and State Maintenance Plan (administered by WPS Health Insurance)*

***Outcomes in Favor of Member includes either fully or partially favorable (Approved or Compromise).*

Navitus Health Solutions (PBM) Grievance Category	Totals	% of Total Grievances
Copayment Reduction	64	37.0%
Experimental	1	0.6%
Non-Covered Drug	55	31.8%
Not Medically Necessary	0	0.0%
Prior Authorization	34	19.7%
Quantity Limit	15	8.7%
Reimbursement Request	4	2.3%
Total	**173**	100%

Resolution Category	Total Grievances
Approved	50
Denied	122
Compromised	0
Withdrawn	1

Independent Review (IR) Requests for State and Local Government Employees – 2007
(listing only those plans that had IR requests)

Plan Name	Number of IRs Requested	Overturned	Upheld	Compromise	Other/ Declined by IR Organization
CompcareBlue Southeast	1	0	1	0	0
Dean Health Plan	1	1	0	0	0
GHC-EC	1	1	0	0	0
GHC-SCW	1	0	1	0	0
Gundersen Lutheran Health Plan	1	0	1	0	0
Health Tradition Health Plan	2	0	2	0	0
Humana Eastern	1	1	0	0	0
Humana Western	1	1	0	0	0
Navitus	1	0	1	0	0
Network Health Plan	0	0	0	0	0
Physicians Plus	1	0	1	0	0
Self-funded Plans*	4	2	1	1	0
UnitedHealthcare Northeast	2	0	0	1	1
UnitedHealthcare Southeast	1	0	0	0	1
Unity UW Health	2	2	0	0	0
IR Totals	**20**	**8**	**8**	**2**	**2**

**Self-funded Plans include: Standard Plan, State Maintenance Plan, Medicare Plus $1,000,000, and Local Annuitant Health Plan (administered by WPS Health Insurance)*

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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

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

CORRESPONDENCE MEMORANDUM

DATE: May 27, 2008

TO: Group Insurance Board

FROM: Steve Hurley, Director, Quality Assurance Services Bureau
Christina Keeley, Ombudsperson, Quality Assurance Services Bureau
Liz Doss-Anderson, Ombudsperson, Quality Assurance Services Bureau

SUBJECT: Employee Trust Funds (ETF) 2007 Ombudsperson Complaint Report

This report is provided for informational purposes. It contains information regarding health insurance, disability insurance and pharmacy benefit manager (PBM) program inquiries and complaints processed by ETF Ombudspersons in 2007. The report is used to monitor trends and address emerging issues in the insurance programs. Select data will also be included in the Report Card section of the 2009 *It's Your Choice* booklet.

2007 ETF Complaint Activity Report

Below is a summary of formal and informal insurance complaints processed in 2007. As in past years, the Department collected information regarding formal written complaints submitted to the Quality Assurance Services Bureau (QASB) for administrative review. The Department also collected data on informal complaints. Informal complaints are primarily received by telephone and are typically resolved within a few weeks. Informal complaints frequently involve difficulties with a prior authorization, enrollment and eligibility, and claims processing.

The total number of new complaints processed by Ombudspersons across all program types remained relatively level for 2007 at 697 (699 in 2006). Complaints relating to the PBM continue to decline. The Department continues to work closely with the PBM administrator, Navitus Health Solutions, to educate members about their benefits and to resolve issues as efficiently as possible.

A. Health Insurance and Pharmacy Benefit Manager Complaints

Some highlights regarding health insurance and PBM complaints received by Ombudspersons in 2007 include:

<u>Formal Complaints</u>

Formal written complaints for all program types decreased from 107 in 2006 to 98 in 2007.

- WPS, (administrator of the self-funded plans), had the most formal complaints, with almost 35% of all formal health insurance complaints received.
- The three most frequent types of formal complaints were: denials of excluded or non-covered benefits (26%); not medically necessary (17%); and billing/claim processing (9%).

Reviewed and approved by Pam Henning, Administrator, Division of Management Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	06/10/2008	6

- Formal complaints involving the PBM program continued to decrease in 2007 with 11 complaints, down from 21 complaints in 2006.
- Of the 98 formal complaints processed by Ombudspersons in 2007, 33% were resolved in favor of the member.

Informal Contacts/Complaints

In 2007, there were 599 informal contacts for all program types, compared to 592 in 2006. Relative to the number of formal written complaints, the number of informal contacts has increased each year as we continue to educate members that working with their plan to resolve their issues prior to a grievance is often in their best interest. Working collaboratively with members, health plans and employers, Ombudspersons often act as mediators to facilitate a quick resolution to member issues. Informal handling of complaints often eliminates the need for further administrative action by either the plan or the Department.

- WPS had the most informal complaints, with approximately 28% of all informal complaints received by the Department regarding health insurance.
- The three most common types of informal complaints were: billing and claims processing (30%); enrollment and eligibility (24%); and general program provision or design (10%).
- Of the 599 informal contacts made to Ombudspersons in 2007, 189 were "inquiry only," where the member had questions for staff, rather than an issue that required resolution. Of the remaining 410 informal complaints with the possibility of a favorable or unfavorable outcome, Ombudspersons were able to resolve 79% of those complaints in favor of the member.
- There were 42 complaints regarding Navitus, which served approximately 229,000 members in 2007.
- There were 32 complaints that involved DeancareRX/Dean Health Insurance, which provides Medicare D pharmacy benefits for Wisconsin Public Employer retirees - approximately 2,100 members in 2007.

The number of favorable outcomes for both formal and informal complaints illustrates the value of Ombudsperson services for members. Ombudspersons will continue efforts to educate members on the most effective ways to navigate the health care system and to work with their health plans to obtain benefits to which they are entitled.

B. Disability Complaints

Disability complaints include complaints or inquiries related to Income Continuation Insurance (ICI), Long-Term Disability Insurance (LTDI), § 40.63 disability retirement and § 40.65 duty disability programs. Within the Disability Programs, the primary role of an ETF Ombudsperson is to educate members regarding disability benefit program design, assist members in navigating the claim process, and advise members of administrative review rights. In addition, the ETF Ombudsperson works directly with the Aetna Ombudsperson to facilitate resolution of member concerns and provide feedback related to customer service to Aetna.

In 2007, Ombudspersons logged 19 disability benefit complaints, compared to 16 in 2006 and 66 in 2005. Disability complaints have declined greatly since a peak of 176 in 2004. These long-term results reflect well on Aetna's proactive approach to handling claims and use of the case ownership model initiated in late-2005, in which a member is assigned a case owner/case manager within 48 hours of their claim being initiated.

ETF Insurance Complaint Surveys

As in previous years, QASB surveyed members about their satisfaction with services after completion of Ombudsperson review of the member's formal complaint. The 2007 health insurance/PBM survey response rate was 51%, with 38 surveys returned.

The following table reflects responses received from members who requested an Ombudsperson review of a formal complaint in 2007 in comparison with 2006:

SURVEY RESPONSES HEALTH INSURANCE/PBM FORMAL COMPLAINTS		
Survey Category:	2006	2007
Provided Timely Services	86%	84%
Services Were Helpful	82%	87%
Professional & Courteous	92%	97%
Satisfied Overall	76%	82%

The survey data indicates that in general, members are satisfied with the Ombudsperson services offered through ETF and consider it a valuable service. This year we are exploring the concept of moving to an electronic, Web-based survey tool in order to capture survey responses from members with informal complaints. We plan to continue surveying members who use the formal complaint process via Ombudsperson services.

The attached charts provide detailed grievance data. Percentages in the attached charts are approximate due to rounding. Quality Assurance Services Bureau staff will be available at the meeting to answer questions.

Formal Complaints by Program, Complaint Type and Resolution Type - 2007

Formal Complaints by Program Type	Total	% of Total
Health Insurance*	83	84.7%
Pharmacy Benefit Manager (Navitus)	11	11.2%
Epic	2	2.0%
Income Continuation and Disability Programs	1	1.0%
Life Insurance	1	1.0%
Total	**98**	100%

Formal Complaints by Complaint Type	Total	% of Total
Excluded or Non-covered Benefit	26	26.5%
Not Medically Necessary	17	17.3%
Billing or Claims Processing	9	9.2%
Experimental or Investigational	9	9.2%
Unauthorized Services	7	7.1%
Co-payment Reduction**	5	5.1%
Referral	5	5.1%
Enrollment/Eligibility	4	4.1%
Usual, Customary & Reasonable	4	4.1%
Plan Service & Administration	3	3.1%
Annual Deductible	2	2.0%
Coordination of Benefits	2	2.0%
General Program Design	2	2.0%
Prior Authorization	2	2.0%
Overpayment of Benefits	1	1.0%
Total	**98**	100.0%

Complaints by Resolution and Program Type	Health Insurance	Pharmacy Benefit Manager	All Others	Total	% of Total
No Change to Decision	52	9	2	**63**	64.0%
In Favor of Member	29	2	1	**32**	33.0%
Compromise	2	0	1	**3**	3%
Closed No Action	0	0	0	**0**	0%
Total	**83**	**11**	**4**	**98**	100%

*Includes all self-funded and alternate plans - a detailed breakdown of formal complaints by health plan is provided on Attachment B

**Applies only to pharmacy benefits

Formal Health Insurance Complaints by Plan - 2007

Plan Name	ETF Complaints	Percentage of Total ETF Health Insurance Complaints	Percentage of Total Contracts
Arise	1	1.20%	0.74%
CompcareBlue NE	1	1.20%	0.44%
CompcareBlue NW	2	2.41%	0.00%
CompcareBlue SE	1	1.20%	2.38%
Dean Health Plan	11	13.25%	22.08%
GHC Eau Claire	3	3.61%	4.02%
GHC South Central	2	2.41%	8.20%
Gundersen Lutheran	1	1.20%	2.11%
Health Tradition	2	2.41%	2.01%
Humana Eastern	2	2.41%	6.79%
Humana Western	3	3.61%	2.21%
Medical Associates	1	1.20%	0.47%
MercyCare	1	1.20%	0.83%
Network Health Plan	3	3.61%	4.35%
Physicians Plus	1	1.20%	10.61%
Security Health Plan	4	4.82%	3.22%
Self-funded Plans*	29	34.94%	9.54%
UnitedHealthcare Northeast	4	4.82%	4.25%
UnitedHealthcare Southeast	2	2.41%	1.88%
Unity Community	1	1.20%	1.52%
Unity UW Health	5	6.02%	11.98%
WPS Patient Choice 1	3	3.61%	0.30%
WPS Patient Choice 2	0	0.00%	0.07%
Total	**83**	100%	100%

**Self-funded plans include: Standard Plan, Medicare Plus $1,000,000, State Maintenance Plan, and Local Annuitant Health Plan, all administered by WPS Health Insurance*

See Attachment E for Comparison Graphs

Informal Complaints by Program, Complaint Type and Resolution Type - 2007

Informal Complaints by Program Type	Total	% of Total
Health Insurance*	458	76.5%
Pharmacy Benefit Manager - Navitus	42	7.0%
Pharmacy Benefit Manager-Medicare D/DHI	32	5.3%
Disability Benefit Programs-Aetna	18	3.0%
Dental Blue	34	5.7%
Excess Medical/Dental-Epic	4	0.7%
Employee Reimbursement Account-FBMC	4	0.7%
Vision Benefit Manager-Spectera	3	0.5%
Wisconsin Retirement System	3	0.5%
Long-Term Care Insurance	1	0.2%
Total Complaints Received	**599**	100%

Informal Complaints by Complaint Type	Total	% of Total
Billing/Claim Processing	180	30.1%
Enrollment and Eligibility	146	24.4%
General Program Provision or Design	62	10.4%
Coordination of Benefits	29	4.8%
Excluded or Non-covered Benefit	27	4.5%
Access to Care	19	3.2%
Prior Authorization	19	3.2%
Referral	17	2.8%
Not Medically Necessary	16	2.7%
Plan Service & Administration	12	2.0%
Mail Order	12	2.0%
Unauthorized Services	10	1.7%
Annual Income Certification (40.63)	8	1.3%
Prescription Drug	6	1.0%
Usual, Customary & Reasonable	6	1.0%
Emergency Services/Copayment	6	1.0%
Copayment Reduction	5	0.8%
Dental	5	0.8%
Experimental or Investigational	4	0.7%
Initial Disability Claim Processing	4	0.7%
Medical Recertification	2	0.3%
Overpayment	2	0.3%
Annual Deductible	1	0.2%
Quality of Care	1	0.2%
Total	**599**	100%

Informal Complaints by Resolution and Program Type	Health Plans	PBM (Navitus)	PBM Medicare D (DHI)	All Others	Total	Percentage of Total
In Favor of Member	266	18	20	20	**324**	54.1%
Inquiry Only	135	17	12	25	**189**	31.6%
No Change to Decision	49	3	0	17	**69**	11.5%
Compromise	8	4	0	5	**17**	2.8%
Total	**458**	**42**	**32**	**67**	**599**	100%

**Includes all self-funded and alternate plans - a detailed breakdown of formal complaints by health plan is provided on Attachment D*

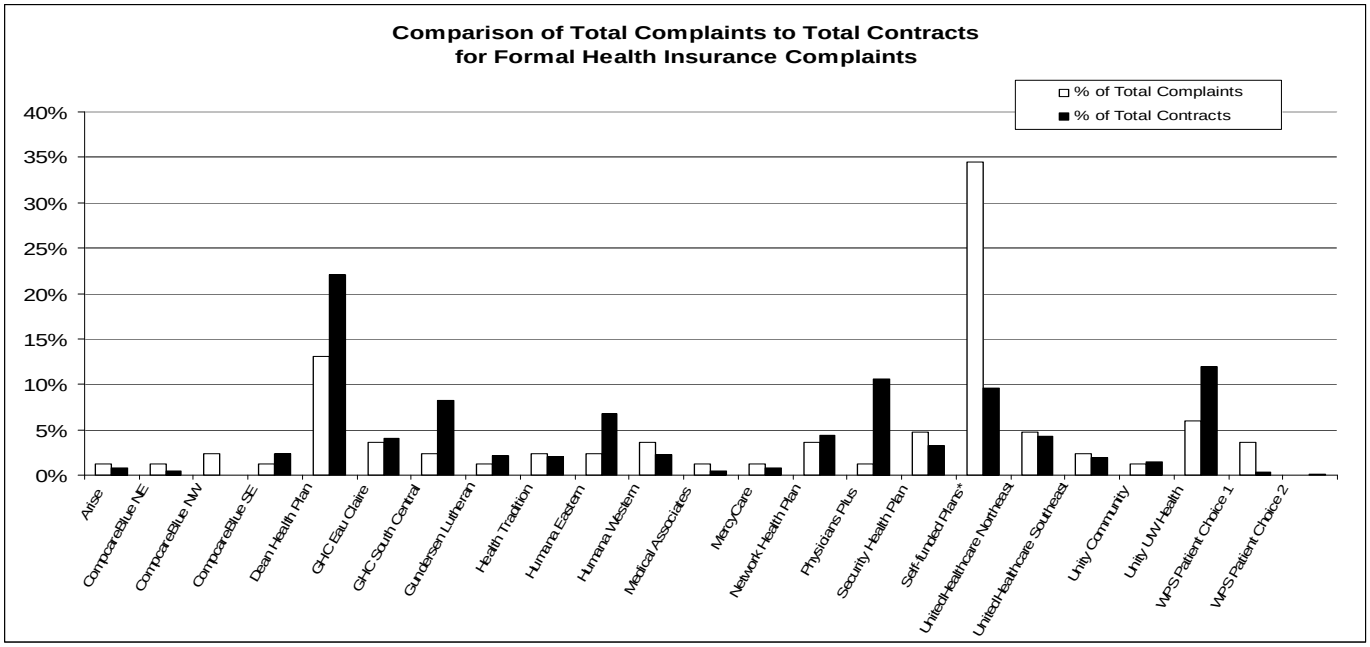
Informal Health Insurance Complaints by Plan - 2007

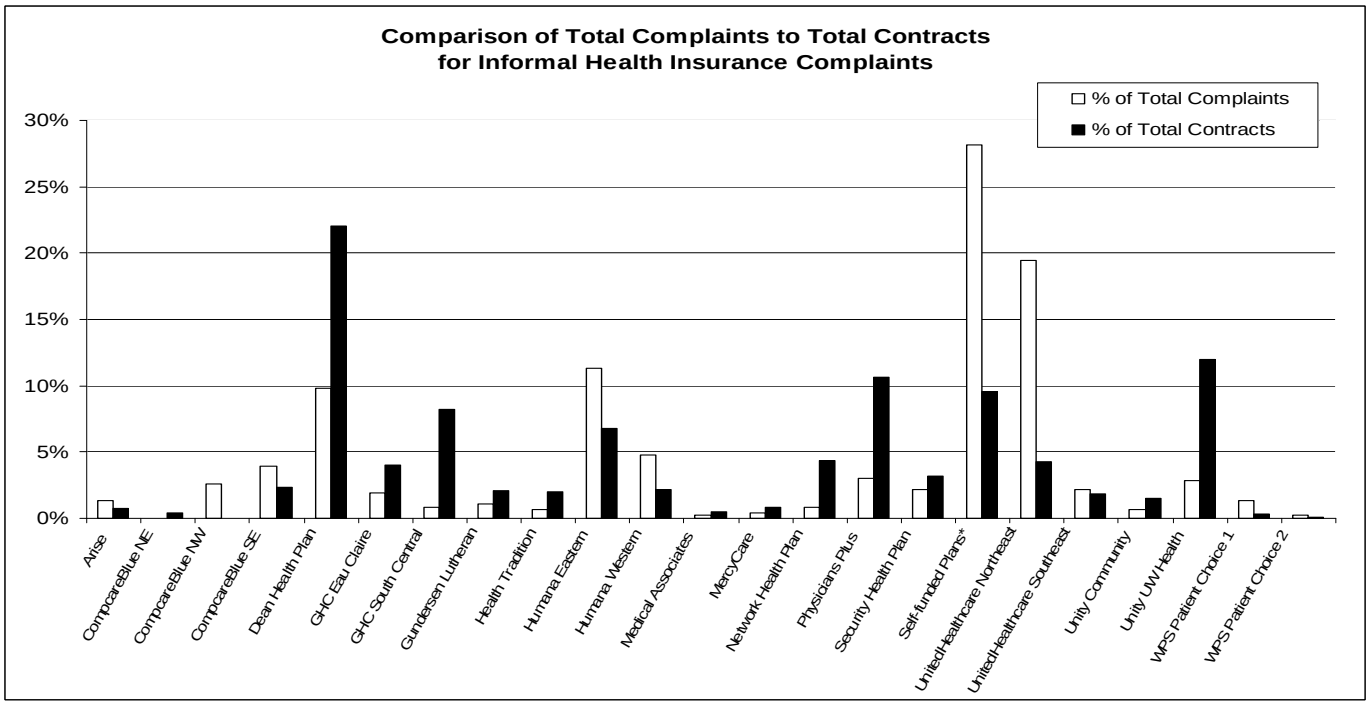
Plan Name	ETF Informal Complaints	Percentage of Total ETF Health Insurance Complaints (Informals)	Percentage of Total Contracts
Arise	6	1.31%	0.74%
CompcareBlue NE	0	0.00%	0.44%
CompcareBlue NW	12	2.62%	N/A
CompcareBlue SE	18	3.93%	2.38%
Dean Health Plan	45	9.83%	22.08%
GHC Eau Claire	9	1.97%	4.02%
GHC South Central	4	0.87%	8.20%
Gundersen Lutheran	5	1.09%	2.11%
Health Tradition	3	0.66%	2.01%
Humana Eastern	52	11.35%	6.79%
Humana Western	22	4.80%	2.21%
Medical Associates	1	0.22%	0.47%
MercyCare	2	0.44%	0.83%
Network Health Plan	4	0.87%	4.35%
Physicians Plus	14	3.06%	10.61%
Security Health Plan	10	2.18%	3.22%
Self-funded Plans*	129	28.17%	9.54%
UnitedHealthcare Northeast	89	19.43%	4.25%
UnitedHealthcare Southeast	10	2.18%	1.88%
Unity Community	3	0.66%	1.52%
Unity UW Health	13	2.84%	11.98%
WPS Patient Choice 1	6	1.31%	0.30%
WPS Patient Choice 2	1	0.22%	0.07%
Total Informal Health Insurance Complaints	**458**	**100%**	**100%**

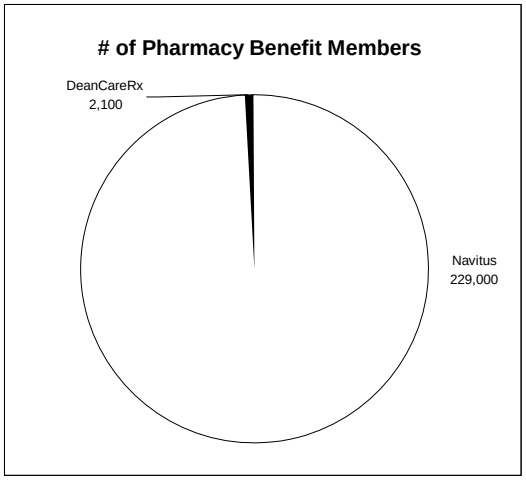
**Self-funded plans include: Standard Plan, Medicare Plus $1,000,000, State Maintenance Plan, and Local Annuitant Health Plan, all administered by WPS Health Insurance*

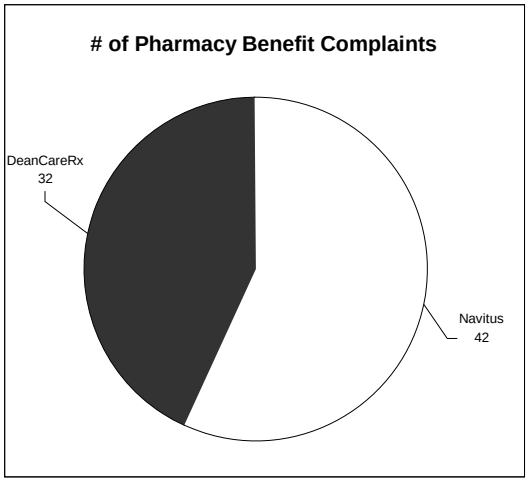
See Attachment E for Comparison Graphs

Comparison Graphs for Formal and Informal Complaints
2007

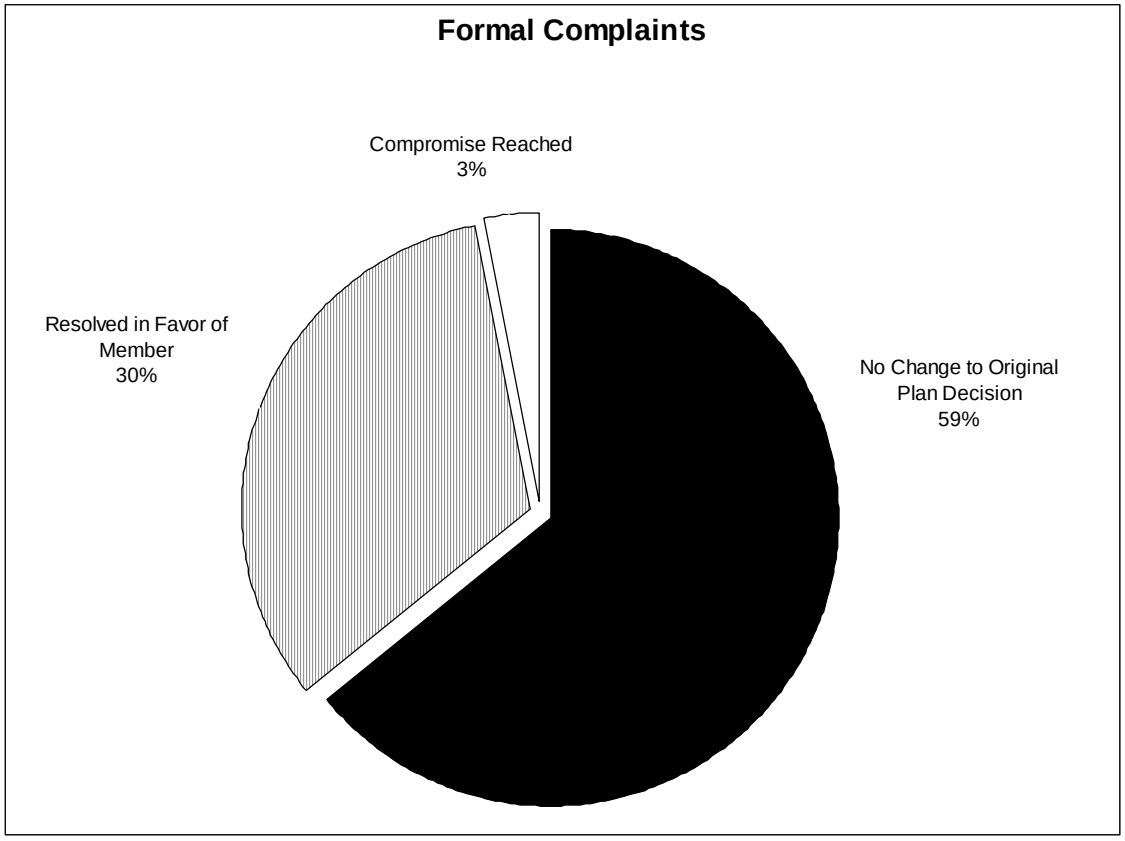


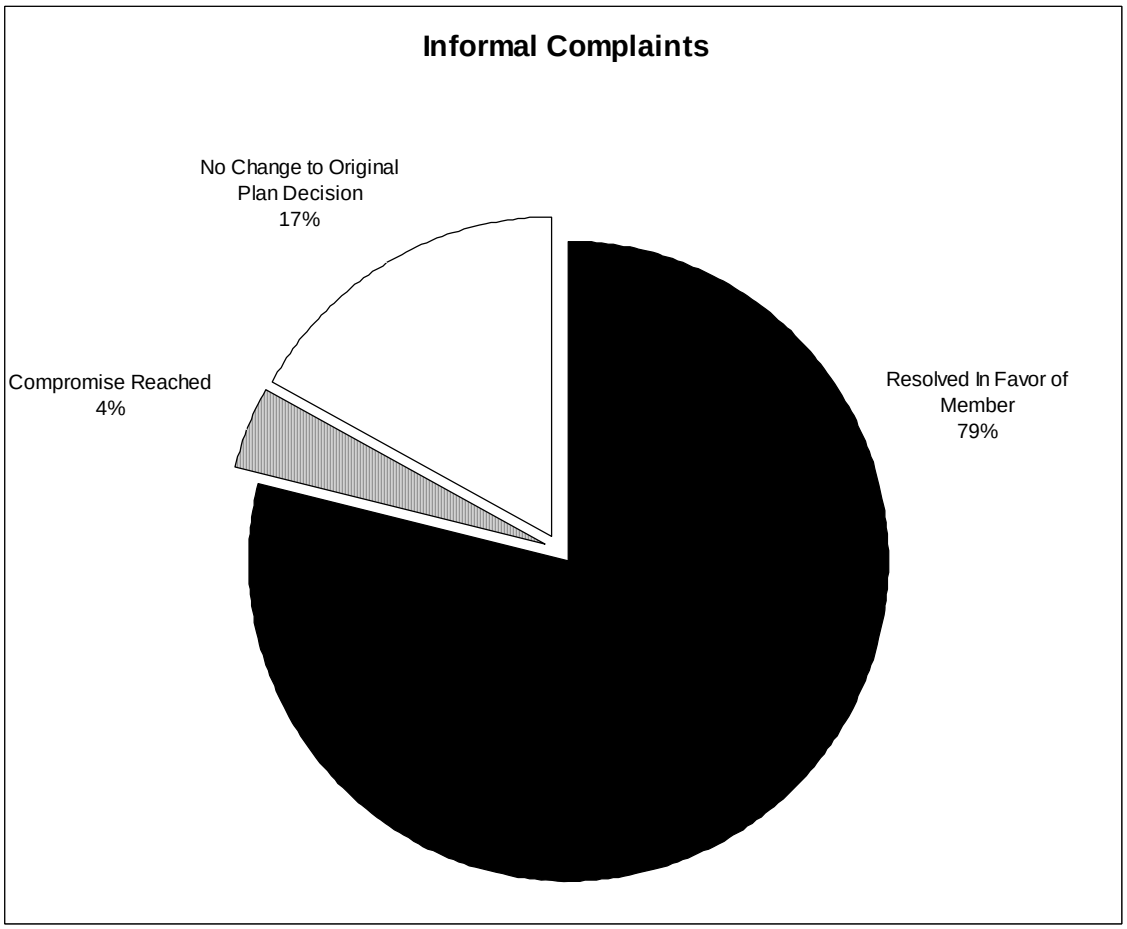






Comparison of Outcomes* (Formal vs. Informal)
2007





*Not including informal complaints that were "inquiry only."

STATE OF WISCONSIN
Department of Employee Trust Funds

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

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

CORRESPONDENCE MEMORANDUM

DATE: May 1, 2008

TO: Group Insurance Board

FROM: Sharon Walk
Appeals Coordinator

SUBJECT: Pending Appeals

PENDING APPEALS BY BOARD						
As of:	ETF	GIB	WR	TR	DC	TOTAL
04/01/08	**13**	**5**	**5**	**1**	**0**	**24**
New Appeals (+)	+3	0	0	0	0	+3
Final Decisions (-)	0	-1	0	-1	0	-2
Appeals Withdrawn (-)	-1	0	0	0	0	-1
05/01/08	**15**	**4**	**5**	**0**	**0**	**24**
+/-	+2	-1	0	-1	0	0

Reviewed and approved by Pam Henning, Administrator, Division of Management Services.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	06/10/2008	6

2008

GROUP INSURANCE BOARD

MEMBERSHIP ROSTER

MEMBER NAME	TERM BEGAN	TERM EXPIRES	MEMBERSHIP REQUIREMENTS
Baird Robert	5/7/07 (5/03-5/07)	5/1/09	§ 15.165 (2) 2-year term Appointed by Governor. Insured participant who is an employee of a local unit of government.
Beil Martin	5/8/07 (10/83-5/07)	5/1/09	§ 15.165 (2) 2-year term Appointed by Governor. Insured participant in WRS who is not a teacher.
Vacant			§ 15.165 (2). 2-year term Appointed by Governor. Chief executive or member of the governing body of a local unit of government that is a participating employer in the WRS.
Doleschal Janis	5/8/07 (5/05-5/07)	5/1/09	§ 15.165 (2) 2-year term Appointed by Governor. Insured participant in WRS who is a retired employee.
Donnelly Jennifer	03/21/07	Ex Officio	§ 15.165 (2). Ex Officio Director of the Office of State Employment Relations or his/her designee.
Frankel (C) Steve	5/8/07 (7/88-5/07)	5/1/09	§ 15.165 (2). 2-year term Appointed by Governor. No membership requirement.
Mallow Eileen	09/18/06	Ex Officio	§ 15.165 (2) Ex Officio Commissioner of Insurance or his/her designee.
O'Donnell (V) Cindy	10/12/05	Ex Officio	§ 15.165 (2) Ex Officio Attorney General or his/her designee.
Olson (S) Esther	5/9/07 (5/01-5/07)	5/1/09	§ 15.165 (2). 2-year term Appointed by Governor. Insured participant in WRS who is a teacher.
Schmiedicke David	11/14/03	Ex Officio	§ 15.165 (2) Ex Officio Secretary of Dept. of Administration or his/her designee.
Sherman Gary	1/24/05	Ex Officio	§ 15.165 (2) Ex Officio Governor or his/her designee.

(C) – Chair (V) – Vice-Chair (S) – Secretary

MAILINGS FOR BOARD MEMBERS SHOULD BE SENT TO:

Group Insurance Board
c/o Board Liaison
Department of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
Phone (608) 267-2417