STATE OF WISCONSIN

GROUP INSURANCE BOARD

HEALTH BENEFIT PLAN

TABLE OF CONTENTS

I. DEFINITIONS 1

II. ENROLLMENT AND ELIGIBILITY ..... 13~~13~~12

A. ENROLLMENT DATA ..... 13~~13~~12
B. SELECTION OF COVERAGE ..... 13~~13~~12
C. DUAL-CHOICE ENROLLMENT PERIODS ..... 16~~16~~15
D. INITIAL PREMIUMS ..... 17~~17~~15
E. CONSTRUCTIVE WAIVER OF COVERAGE ..... 17~~17~~15
F. BENEFITS NON-TRANSFERABLE ..... 17~~17~~16
G. NON-DUPLICATION OF BENFEITS ..... 17~~17~~16
H. REHIRED OR TRANSFERRED EMPLOYEE COVERAGE ..... 17~~17~~16
I. DEFERRED COVERAGE ..... 18~~18~~16
J. COVERAGE OF SPOUSE ..... 18~~18~~17
K. COVERAGE DURING AN UNPAID LEAVE OF ABSENCE ..... 18~~18~~17
L COVERAGE DURING APPEAL FROM REMOVAL OR DISCHARGE ..... 19~~19~~18
M. CONTINUED COVERAGE OF SURVIVING DEPENDENTS ..... 20~~20~~18
N. COVERAGE OF EMPLOYEES AFTER RETIREMENT ..... 20~~20~~19
O COVERAGE OF ANNUITANTS AND SURVIVING DEPENDENTS ELIGIBLE FOR MEDICARE 21~~21~~19
P. CONTRACT TERMINATION ..... 22~~22~~20
Q. INDIVIDUAL TERMINATION OF COVERAGE ..... 22~~22~~21
R. COVERAGE CERTIFICATION ..... 24~~24~~23
S. ADMINISTRATION OF BENEFIT MAXIMUMS UNDER UNIFORM BENEFITS ..... 25~~25~~23

III. STANDARD PLAN SCHEDULE OF BENEFITS ..... 26~~26~~24

A. DEDUCTIBLE ..... 26~~26~~24
B. COINSURANCE ..... 26~~26~~24
C. ANNUAL OUT-OF-POCKET LIMIT ..... 27~~27~~25
D. LIFETIME MAXIMUM BENEFITS ..... 28~~28~~26

IV. STANDARD PLAN HOSPITAL, PROFESSIONAL AND OTHER SERVICES ..... 29~~29~~27

A. HOSPITAL SERVICES ..... 29~~29~~27
B. OUTPATIENT MISCELLANEOUS HOSPITAL EXPENSES ..... 32~~32~~30
C. PROFESSIONAL AND OTHER SERVICES ..... 32~~32~~30

V. SMP BENEFITS ..... 43~~43~~39

VI. WISCONSIN PUBLIC EMPLOYERS STANDARD PLAN ..... 44~~44~~40

A. GROUP ADMINISTRATION ..... 44~~44~~40
B. BENEFITS ..... 44~~44~~40
C. DEDUCTIBLE STANDARD PLAN BENEFITS ..... 58~~58~~52
D. STANDARD PREFERRED PROVIDER PLAN (PPP) ..... 59~~59~~53
E. DEDUCTIBLE STANDARD PREFERRED PROVIDER PLAN (PPP) ..... 63~~63~~57
F. STATE MAINTENANCE PLAN. ..... 66~~66~~60
G. DEDUCTIBLE SMP – WISCONSIN PUBLIC EMPLOYERS ..... 69~~69~~63

VII. MEDICARE PLUS $1,000,000 COVERAGE ..... 71~~71~~65

A. DEFINITIONS ..... 71~~71~~65
B. BENEFITS AVAILABLE ..... 71~~71~~65

VIII. TRANSPLANTATIONS, IMPLANTATIONS AND GRAFTING ..... 78~~78~~72

A. BENEFITS ..... 78~~78~~72
B. EXCLUSIONS ..... 80~~80~~74

IX. COORDINATED HOME CARE, HOME CARE AND HOSPICE CARE SERVICES ..... 81~~81~~75

A. HOME CARE SERVICES ..... 81~~81~~75
B. HOSPICE CARE SERVICES ..... 83~~83~~77

X. VALUE CARE PROGRAM ..... **85~~85~~~~79~~**

A. PREADMISSION AND CONTINUED STAY CERTIFICATIONS ..... 85~~85~~~~79~~
B. PRENATAL AND MATERNITY CARE NOTIFICATION ..... 88~~88~~~~82~~
C. DISEASE CASE MANAGEMENT ..... 88~~88~~~~82~~

XI. WAITING PERIODS FOR PRE-EXISTING CONDITIONS ..... **89~~89~~~~83~~**

XII. EXCLUSIONS ..... **90~~90~~~~84~~**

XIII. PREAUTHORIZATION ..... **93~~93~~~~87~~**

XIV. GENERAL CONDITIONS ..... **94~~94~~~~88~~**

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.