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CORRESPONDENCE MEMORANDUM

DATE: August 10, 2011

TO: Group Insurance Board

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

SUBJECT: Guidelines/Uniform Benefits/Standard Plan:
Changes & Clarifications to Health Insurance Contracts

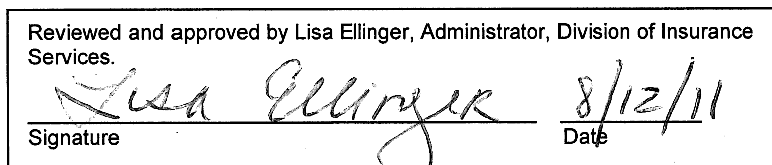
Staff recommends the Group Insurance Board (Board):

Adopt the Guidelines, Uniform Benefits and Standard Plan amendments as discussed below and authorize staff to make additional technical clarifications as may be required.

At its June 28, 2011, meeting, the Board reviewed and approved changes for the 2012 benefit year in order to comply with 2011 Wisconsin Act 10. At that time, staff noted language changes would be brought back to the Board in addition to further amendments that are now necessary due to the biennial budget, 2011 Wisconsin Act 32, which was published on June 30, 2011.

The following includes a brief description of the amendments and attached language changes that illustrate the contract for 2012. New language is shaded and underscored and language to be deleted is ~~stricken~~. Where appropriate, the recommendations also apply to the Standard Plan contracts (both the Health Benefit Plan and Professional Administrative Services Agreement (PASA)) and staff will make the necessary changes.

- **Attachment 1** – Explains the basis for noteworthy changes to the Guidelines, State, Local and Uniform Benefits contracts.
- **Attachment 2** – Provides the language changes for the Guidelines, State, Local and Uniform Benefits contracts for the alternate health plans.
- **Attachment 3** – Explains the basis for significant changes to the Standard Plan contract.



Reviewed and approved by Lisa Ellinger, Administrator, Division of Insurance Services.

Signature: Lisa Ellinger Date: 8/12/11

Board	Mtg Date	Item #
GIB	8.23.11	5A

- **Attachment 4** – Provides the language changes for the Standard Plan contracts administered by WPS Health Insurance (WPS).

Pursuant to Wis. Stat. § 40.03 (6) (c), the Board is not prohibited from making cost effective changes to the benefit plan.

Further technical clarifications may be necessary, as staff continue to review state law. Staff will advise the Board at a later date, but is also requesting authority to proceed with any needed technical clarifications.

AMENDMENTS FOR 2012:

1. **Definition of Dependent:** Consistent with 2011 Wisconsin Act 32, staff made changes to dependent eligibility for health insurance coverage relating to married dependents and eligibility based on the cost of coverage. In both cases, eligibility is now consistent with federal law such that neither marriage nor eligibility for other group coverage results in a loss of eligibility for our coverage. References have been updated in all contracts as appropriate. Attached is the language from the State contract.

2. **Dropping Coverage -- Adult Dependents:** Staff recommends a modification to allow a subscriber to drop coverage for an adult child when they enroll in another plan. Previously this provision limited such a change to the dependent's initial enrollment opportunity in part. The new language will broaden the opportunities to allow for changes such as open enrollments that the dependent may be offered.

3. **Employee enrollment opportunity immediately prior to retirement to preserve sick leave:** Per Board action at its June 7, 2011 meeting, staff has added language to allow uninsured State and Local employees to enter the program immediately prior to retirement in order to preserve sick leave credits.

4. **COBRA Continuation:** Following Board approval on June 28, 2011, staff has added language to align continuation coverage for appropriate State and Local members with federal and state law. Typically, this limits coverage to 18 months. This change does not apply to individuals who experience a layoff. They will be able to continue coverage for 36 months.

5. **Local flexibility to offer both the Traditional HMO and Deductible HMO by collective bargaining unit:** Staff has received several requests to allow local employers additional flexibility to offer the Deductible HMO plan along with the Traditional HMO plan, varying by collective bargaining unit. Neither staff, the actuary, nor any of several plans contacted have concerns about this from a risk standpoint. Therefore, staff recommends approval, pending resolution of some system administrative issues.

6. **Local health insurance premium contributions:** 2011 Wisconsin Act 10 requires that participating Wisconsin Public Employers contribute no more than 88% of the average premium cost of plans offered in any tier with the lowest employee premium cost. Staff has clarified language to align this requirement in the service area of the employer and is pursuing similar updates to our administrative code ETF 40.10 (2). It also clarifies that the 88% requirement is based on plans in the service area of the employer.

7. **Uniform Benefits changes:** Benefit change language for State non-Medicare members that was approved by the Board at its June 28, 2011 meeting is included. It describes the:

   a. coinsurance benefits
   b. emergency room copayment
   c. coverage of dental implants following illness or injury
   d. definition of dependent
   e. palliative care consult benefit
   f. change to the prescription drug plan as described in a separate memo to the Board on the Employer Group Waiver Plan (item 10A)

8. **Standard Plan changes:** Contract language to address the benefit changes and modernization of the State Standard Plan are attached to this memo. The Board approved the concepts that guided this language at its June 28, 2011 meeting. Overall, the net effect of the benefit changes makes the State Standard plan more cost effective.

   Included with this memo is attachment 3 from the June 28 meeting. Immediately preceding each bullet are references to the contractual articles that are being modified and the applicable page numbers for attachment 4.

   Attachment 4 provides specific language to show the deductible, coinsurance and emergency room copayment changes that were likewise adopted on June 28. Coverage in full for routine, preventive care due to the loss of grandfathering under federal health care reform is also described. Parallel changes approved for Uniform Benefits that apply to all plans, such as the dependent definition and elimination of pre-existing waiting periods, were made in a consistent manner but are not included here.

   A number of items in Attachment 4 have been clarified:

   - Donor expenses for transplants are only covered when included as part of the participant's bill.
   - Services for sexual dysfunction are not medically necessary and are therefore excluded.

- A change to the exclusion for refractive surgery is not necessary as the issue was determined to be a reconstructive surgery, and the current exclusion is appropriate.

In addition, staff has included an update to the criteria for gastric bypass surgery to align the contract with current WPS medical policy. Periodically, such updates are recommended by WPS and ETF staff. Except for this gastric bypass provision, the specified updates apply only to the State Standard Plan.

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

Attachments: Attachment 1 (Notable Changes Under Consideration for the 2012 Guidelines and State, Local and Uniform Benefits Contracts)
Attachment 2 (Contract)
Attachment 3 (Reduce Standard Plan benefits and modernize)
Attachment 4 (Standard Plan Contract)

Notable Changes Under Consideration for the 2012
Guidelines and State, Local and Uniform Benefits Contracts

Section & Page Number (in Attachment 2)	Description	Reason for Change
Article 1.7 Definitions *Page 1*	Update Dependent definition.	Technical change due to Act 32 regarding Wis. Stat. 632.885.
Article 3.3 (11) *Pages 2 & 3*	a) Updated language so that neither marriage nor eligibility for other group coverage results in a loss of eligibility for our coverage. b) Modified information regarding when an adult child can be dropped from a family contract to include when they enroll in another plan.	a) Technical change due to Act 32 regarding Wis. Stat. 632.885. b) Recommended by staff.
Article 3.10 (5) *Page 4*	Added language to allow uninsured employees to enter the program immediately prior to retirement in order to preserve sick leave credits.	Board approval at June 7, 2011 meeting.
Article 3.18 *Page 5*	Added language to allow continuation coverage to align with the 18 month requirement in federal law.	Board approval at June 28, 2011 meeting.
Local Only Article 3.1 *Page 6*	Allows a local employer to offer both Traditional and Deductible HMO plans by collective bargaining status.	Requested by local employers.
Local Only Article 3.21 *Page 7*	Participating employer may contribute no more than 88% of the average cost of plans offered.	Technical change due to Act 10~~1~~.
Schedule of Benefits *Pages 8, 9 & 10*	Coinsurance benefit for State non-Medicare members versus all other eligibles.	Board approval at June 28, 2011 meeting as required by Act 10.
Schedule of Benefits *Pages 9 & 11*	Emergency Room copayment.	Board approval at June 28, 2011 meeting as required by Act 10.

Section & Page Number (in Attachment 2)	Description	Reason for Change
Schedule of Benefits & Benefits and Services *Pages 10 & 14*	Dental implant coverage.	Board approval at June 28, 2011 meeting.
Definitions *Page 12*	Update Dependent definition.	Technical change due to Act 32 regarding Wis. Stat. 632.885.
Benefits and Services *Pages 13, 15, 16, 17 & 18*	Coinsurance changes.	Board approval at June 28, 2011 meeting.
Benefits and Services *Page 14*	Palliative care.	Board approval at June 28, 2011 meeting.
Benefits and Services *Page 19*	Change due to prescription drug Employer Group Waiver Plan.	Per item 9.A. of the August 23, 2011 meeting.
Exclusions and Limitations *Page 20*	Coinsurance changes.	Board approval at June 28, 2011 meeting.

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

(b) After attaining age 26, as required by Wis. Stat. § 632.885, a DEPENDENT includes a child that ~~is not married and is not eligible for coverage under a group health insurance plan that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a DEPENDENT under this program. The child ceases to be a Dependent at the end of the month in which he or she:~~

- ~~turns 27 years of age, or~~
- is no longer a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

(4) A child born outside of marriage becomes a Dependent of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The Effective Date of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

(5) A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

(6) Any DEPENDENT eligible for BENEFITS who is not listed on an application for coverage will be provided BENEFITS based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the EMPLOYER, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

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

- Each individual is at least 18 years old and otherwise competent to enter into a contract.
- Neither individual is married to, or in a domestic partnership with, another individual.

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

(d) Coverage under this provision shall be effective on the date of termination of the prior plan or the date of the event described in (b) or (c) 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.

(8) In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary physician, clinic or care system that is not available in the plan selected, the HEALTH PLAN shall immediately notify the EMPLOYER. The SUBSCRIBER shall be allowed to correct the plan selected to one which has that physician, clinic or care system 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. The HEALTH PLAN may not simply reassign a primary physician, clinic or care system.

(9) PARTICIPANTS who have escrowed their sick leave or have their sick leave preserved as provided for in statute may reenroll in any HEALTH 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 be effective 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 and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. A PARTICIPANT enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS are covered under the other plan and 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. 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.

(10) Eligible retired EMPLOYEES or former EMPLOYEES of the State who have reenrolled under section 3.10 (4) may select any offered plan.

(11) A SUBSCRIBER who does not request coverage for a DOMESTIC PARTNER, or an adult child when first eligible under Wis. Stat. § 632.885, will thereafter be limited to enrolling the DOMESTIC PARTNER or child when the DOMESTIC PARTNER or child become newly eligible due to the loss of eligibility for other coverage or the loss of employer contribution for the other coverage~~, or the child has an increase in employee contribution share that exceeds the cost of coverage as a dependent under this program, or gets divorced~~. The SUBSCRIBER can add the DEPENDENT by filing an application with the EMPLOYER within 30 days of the event

and coverage for the DEPENDENT will be effective on the event date. This paragraph does not prevent a SUBSCRIBER from adding the eligible DEPENDENT during the DUAL-CHOICE enrollment period for coverage effective the following January 1.

Coverage for the DEPENDENT eligible under this section remains in effect until the DEPENDENT is no longer eligible, the family coverage is terminated, the DEPENDENT enrolls in other health insurance coverage during an ~~initial~~ enrollment opportunity, or the SUBSCRIBER requests to terminate the coverage for the DEPENDENT effective the following January 1, whichever occurs first.

(12) An eligible EMPLOYEE who is insured as a DEPENDENT child on another policy in this program can enroll for coverage by submitting an application during the annual DUAL-CHOICE enrollment period for coverage effective the following January 1.

3.4 DUAL-CHOICE ENROLLMENT PERIODS

(1) The BOARD shall establish enrollment periods, which shall permit eligible EMPLOYEES, ANNUITANTS and CONTINUANTS to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 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, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines for a minimum of three months. The newly selected plan must have in-network providers in the county to which the SUBSCRIBER moved, as shown in the annual DUAL-CHOICE enrollment materials. 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) A SUBSCRIBER under (3) and (4) above who does not file an application to change plans within this 30 day enrollment period may change plans at the next DUAL-CHOICE enrollment period.

(6) As required by Federal law, an insured EMPLOYEE or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, domestic partnership, birth, adoption, placement for adoption, loss of other coverage or loss of employer contribution for the other coverage may change HEALTH PLANS after the event if an application is submitted within 30 days of the event. This enrollment opportunity also applies when adding a dependent due to

(5) An eligible EMPLOYEE who is not enrolled for coverage, may enroll in the STANDARD PLAN 30 days prior to retirement for the purpose of delaying initiation of post-retirement EMPLOYER premium contribution per Wis. Stat. § 40.05 (4) (b).

3.11 COVERAGE OF SPOUSE OR DOMESTIC PARTNER

(1) If both spouses are ANNUITANTS or employed through the State of Wisconsin or a participating Wisconsin Public Employer and both are eligible for coverage, each may elect individual 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. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family 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 EMPLOYER receives the application, or 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 HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. 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.

(2) If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one DOMESTIC PARTNER elects family coverage, the other eligible DOMESTIC PARTNER may be covered as a DEPENDENT but may not have any other coverage except if necessary to avoid imputed income. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one DOMESTIC PARTNER to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the DOMESTIC PARTNERS have coverage with different HEALTH PLANS at the time of the effective date of the domestic partnership or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the domestic partnership terminate while carrying family coverage, the former DOMESTIC PARTNER may elect coverage without lapse if the EMPLOYER received the application within 30 days of the termination of domestic partnership.

3.12 COVERAGE DURING AN UNPAID LEAVE OF ABSENCE

(1) Any insured EMPLOYEE may continue coverage during any EMPLOYER approved leave of absence or LAYOFF for up to 36 months. Insurance 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. Stat. § 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, the EMPLOYEE is not deemed to have returned to work and coverage as an active EMPLOYEE shall not be resumed.

(c) The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage while on a leave of absence or LAYOFF, as provided in section 3.12.

(d) The end of the month in which a notice of cancellation of coverage or sick leave escrow application is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT or CONTINUANT, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. If the ANNUITANT or CONTINUANT contacts the HEALTH PLAN directly to cancel coverage, the HEALTH PLAN is to 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, end of a domestic partnership, etc.). As required by Wis. Stat. §632.897, if family coverage remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification of continuation of coverage rights occurs. The EMPLOYER may collect PREMIUM retroactively from the SUBSCRIBER if the divorce was not reported in a timely manner and there were no other eligible DEPENDENTS for family coverage to remain in effect.

(f) The expiration of the continuation period ~~36 months~~ for which the PARTICIPANT is allowed to continue under paragraph (4) below, 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 preexisting condition of PARTICIPANT who continues under paragraph (4) below.

(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 sub. (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~~.~~ except that coverage ends the end of the month of termination of employment, refunds shall be made back to the end of that month.

(3) Except when a PARTICIPANT'S coverage terminates because of voluntary 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 PARTICIPANT who ceases to meet the definition of EMPLOYEE, ANNUITANT, or DEPENDENT may elect to continue group coverage ~~for a maximum of 36 months~~as required by state and federal law. Application must be postmarked within 60 days of the date the PARTICIPANT is notified of the right to continue or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for the required PREMIUM.

Wisconsin Public Employer Contract Only

ARTICLE 3 COVERAGE

3.1 EFFECTIVE DATE

(1) The group health insurance program as required by Wis. Stat. § 40.51 (7), and under which the HEALTH PLAN is participating according to the terms of this CONTRACT, shall be available beginning July 1, 1987. As recommended by the DEPARTMENT'S actuary and approved by the BOARD, requirements apply to municipalities joining the program and a surcharge applied when the risk is determined to be detrimental to the existing pool. The surcharge is determined by the BOARD's actuary and cannot be appealed. The DEPARTMENT reserves the right to separately rate underwritten groups larger than 2,000 total members, as recommended by the actuary.

(2) The governing body of an EMPLOYER shall adopt a resolution for regular or deductible option coverage in a form prescribed by the DEPARTMENT. An employer may elect to provide both regular and deductible options separately to collective bargaining units as approved by the DEPARTMENT. The resolution may provide for underwriting or rate differential as deemed appropriate by the BOARD'S actuary to be passed back to the HEALTH PLANS as determined by the DEPARTMENT in consultation with the BOARD'S actuary. The EFFECTIVE DATE of coverage shall be the beginning of the calendar month, or the beginning of the quarter for EMPLOYERS receiving a rate differential as determined through underwriting, on or after 90 days following receipt by the DEPARTMENT of the resolution, unless the resolution specifies a later month and is approved by the DEPARTMENT. At least 40 days prior to the EFFECTIVE DATE, the DEPARTMENT must receive from the EMPLOYER all EMPLOYEE and ANNUITANT applications for which coverage will begin on the EFFECTIVE DATE. If the number of EMPLOYEE applications received does not represent the minimum participation level of at least 65% of the eligible EMPLOYEES or for small EMPLOYERS as defined under Wis. Stat. § 635.02 (7), the minimum participation level in accordance with Wis. Adm. Code § INS 8.46 (2), the resolution shall become void.

EMPLOYEES who are on a leave of absence and not insured under the EMPLOYER'S plan are eligible to enroll only under section 3.10 if they returned to active employment. For ANNUITANTS and EMPLOYEES on leave of absence to be eligible under this section, they must be insured under the EMPLOYER'S current group health plan. Eligible EMPLOYEES who are not insured under the EMPLOYER'S current group health plan at the time the resolution to participate is filed or evidence of insurability is required, or those insured for single coverage who are enrolling for family coverage, shall be subject to the deferred coverage provisions of section 3.10. This limitation will not apply to PARTICIPANTS insured under another group health insurance plan administered by the DEPARTMENT. Those insured through the employer's group coverage at the time the resolution is filed who do not meet the definition of eligible employee under this program may elect continuation coverage for up to 36 months or the length of time continuation coverage would be available under the previous insurer, whichever is less.

3) Notwithstanding section 3.2, any EMPLOYER for whom the resolution made under section 3.1 resulted in coverage effective January 1, 1988 or after shall be required to remain in the program for a minimum of 12 months. Any EMPLOYER who files a resolution after

Wisconsin Public Employer Contract Only

3.20 ADMINISTRATION OF BENEFIT MAXIMUMS UNDER UNIFORM BENEFITS

(1) If a PARTICIPANT changes HEALTH PLANS during a CONTRACT year (e.g., due to a change in residence), any annual BENEFIT maximums under Uniform Benefits will start over at $0 with the new HEALTH PLAN as of the effective date of coverage with the new HEALTH PLAN with the exception of the prescription annual out-of-pocket maximum.

(2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER transfer resulting in a change of SUBSCRIBER, but does not change HEALTH PLANS, the annual BENEFIT maximums will continue to accumulate for that year.

(3) The HEALTH PLAN shall provide the PARTCIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of a plan explanation of benefits.

3.21 EMPLOYER CONTRIBUTIONS TOWARD PREMIUM

(1) The EMPLOYER contribution toward PREMIUM for any EMPLOYEE shall be at least 50% but not more than ~~105~~88% of the gross PREMIUM of the ~~lowest~~average cost qualified alternate plan approved by the BOARD which is in the service area of the EMPLOYER. EMPLOYERS who determine the EMPLOYEE PREMIUM contribution based on the tiered structure established for state EMPLOYEES must do so in accordance with Wis. Adm. Code § ETF 40.10. The DEPARTMENT shall determine the service area of the EMPLOYER. The effective date of the EMPLOYER contribution shall not be later than the first of the month after which the EMPLOYEE completes 6 months service with the EMPLOYER under the Wisconsin Retirement System.

(2) Notwithstanding sub. (1), the amount of EMPLOYER contribution toward PREMIUM for ANNUITANTS, EMPLOYEES on approved leave of absence or LAYOFF, or those whose coverage is continued under section 2.9 (1) shall be at the discretion of the EMPLOYER.

(3) The minimum contribution for an EMPLOYEE who is appointed to work less than 1,044 hours per year shall be 25% of the lowest cost qualified alternate plan that is in the service area of the EMPLOYER and approved by the BOARD.

(4) If the amount of EMPLOYER contribution changes, a new DUAL-CHOICE offering may be made to its EMPLOYEES, as determined by the DEPARTMENT.

(5) ANNUITANTS for whom the EMPLOYER contributes toward the PREMIUM shall be treated as EMPLOYEES for the purpose of PREMIUM and coverage reporting.

I. SCHEDULE OF BENEFITS

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

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

NOTE: - *Employees and retirees of participating local governments that have selected the deductible option have an up-front deductible of $500 per individual / $1,000 per family, per calendar year for all medical services except for preventive services required under Section III., A., 5., i. Benefits administered by the PBM do not apply toward the deductible. After the deductible is met, Uniform Benefits are administered as outlined below.*

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

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

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

- ~~Policy Deductible: NONE~~
- Policy Coinsurance and medical Copayments: ~~100% of charges, except as~~ described below

Benefit	**State of Wisconsin eligible Particpants who are not eligible for nor enrolled in Medicare as the primary payor**	**Medicare prime State of Wisconsin Participants and all participating Wisconsin Public Employer's eligible Participants**
Routine, preventive services as required by federal law	100%	100%

Illness/injury related services	90% to the annual out-of-pocket of maximum (OOPM) not to exceed $500 per individual / $1,000 per family.	100%
Emergency Room Copay (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	$75 does not accumulate to OOPM, 90% coinsurance thereafter to OOPM.	$60
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% to the annual out-of-pocket of maximum (OOPM) not to exceed $500 per individual / $1,000 per family.	80% to an annual OOPM of $500 per Participant
Cochlear Implants for Participants age 18 and older	90% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use.	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use.
Cochlear Implants Participants under age 18	90% up to the annual OOPM for hospital charges, device, surgery for implantation and follow-up sessions to train on use.	100% hospital, device, surgery for implantation and follow-up sessions to train on use.
Hearing Aids for Participants age 18 and older	80%	80%
Hearing Aids for Participants under age 18	90% up the annual OOPM.	100%

- Policy Deductible: NONE
- Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: NONE
- Outpatient Physical, Speech and Occupational Therapy Maximum: Covered up to 50 visits per Participant for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be available when Prior Authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per Participant per calendar year.

- ~~Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies Coinsurance: Payable at 80%. Out-of-pocket expense will not exceed $500 individual / $1,000 per family annually per Participant.~~

- Cochlear Implants: Device, surgery for implantation of the device, ~~and~~ follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan~~,~~ ~~payable at 80%.~~ ; and Hospital charges ~~for the surgery are covered at 100%~~. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum~~for Durable Medical Equipment~~. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable as described in the preceding grid ~~at 100%~~.

- Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid~~at 80%~~, up to a maximum payment of $1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum~~for Durable Medical Equipment~~. As required by Wis. Stat. §632.895 (16), hearing aids for Participants under 18 years of age are payable as described in the preceding grid ~~at 100%~~and the $1,000 limit does not apply.

- Home Care Benefits Maximum: 50 visits per Participant per calendar year. 50 additional Medically Necessary visits per Participant per calendar year may be available when authorized by the Health Plan.

- Hospice Care Benefits: Covered when the Participant's life expectancy is six months or less, as authorized by the Health Plan.

- Transplants: Limited to transplants listed in Benefits and Services section.

- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.

- Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.

- Vision Services: One routine exam per Participant per calendar year. Non-routine eye exams are covered as Medically Necessary. (Contact lens fittings are not part of the routine exam and are not covered.)

- Oral Surgery: Limited to procedures listed in Benefits and Services section.

- Temporomandibular Disorders: The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per Participant per calendar year. Intraoral splints are subject to the Durable Medical Equipment Coinsurance (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

- Dental Implants: Following accident or injury, up to a maximum payment of $1,000 per tooth.

- Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services section. However, each Health Plan may choose to provide a dental plan to all of its members.

- ~~Hospital Emergency Room Copayment: $60 per visit; waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.~~

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

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

  *Level 1 consists of Formulary Generic Drugs and certain low cost Brand Name Drugs.
  **Level 2 consists of Formulary Brand Name Drugs and certain higher cost Generic Drugs.

  Annual Out-of-Pocket Maximum (The amount You pay for Your Level 1 and Level 2 prescription drugs and insulin):
  $410 per individual or $820 per family for all Participants, except:
  $1,000 per individual or $2,000 per family for State Participants enrolled in the Standard Plan, and
  No annual out-of-pocket maximum for Wisconsin Public Employer Participants enrolled in the Standard Plan or State Maintenance Plan (SMP)

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

- Disposable Diabetic Supplies and Glucometers Coinsurance: Payable at 80%, which will be applied to the prescription drug annual out-of-pocket maximum.

- Smoking Cessation: One consecutive three-month course of pharmacotherapy covered per calendar year.

- **DEPARTMENT:** Means Department of Employee Trust Funds.

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

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

2. A spouse and a stepchild cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment. A Domestic Partner and his or her children cease to be Dependents at the end of the month in which the domestic partnership is no longer in effect.

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

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

   ~~b. After attaining age 26, as required by Wis. Stat. § 632.885 and Wis. Adm. Code § INS 3.34, a Dependent includes a child that is not married and is not eligible for coverage under a group health insurance plan that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a Dependent under this program. The child ceases to be a Dependent at the end of the month in which he or she:~~
   - ~~turns 27 years of age, or~~
   - ~~is no longer a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.~~

4. A child born outside of marriage becomes a Dependent of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with

III. BENEFITS AND SERVICES

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

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

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

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

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

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

A. Medical/Surgical Services

1. Emergency Care

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

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

c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility

Medical Supplies and services, counseling, bereavement counseling for one year after the Participant's death, Durable Medical Equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a six-month period if authorized by the Health Plan.

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

14. Phase II Cardiac Rehabilitation

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

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

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

16. Oral Surgery

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

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

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

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

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

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

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

g. Intraoral and extraoral incision and drainage of cellulitis.

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

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

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

c. Kidney Transplants. See item 19. below.

19. Kidney Disease Treatment

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

20. Chiropractic Services

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

21. Women's Health and Cancer Act of 1998

Under the Women's Health and Cancer Act of 1998, coverage for the treatment of breast cancer includes:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses (see DME in Section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas;
- Breast implants~~, which are not subject to coinsurance~~.

22. Smoking Cessation

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

B. Institutional Services

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

1. Inpatient Care

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

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

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

2. Outpatient Care

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

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

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

Surgical Care: Covered.

C. Other Medical Services

1. Mental Health Services/Alcohol and Drug Abuse

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

a. Outpatient Services

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

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

b. Transitional Services

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

c. Inpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits and as required by Wis. Stat. §632.89 and Wis. Adm. Code § INS

d. Other

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

2. Durable Diabetic Equipment and Related Supplies

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

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

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

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

3. Medical Supplies and Durable Medical Equipment

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

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

- Initial acquisition of artificial limbs or eyes or as needed for growth and development.
- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- Rental or, at the option of the Health Plan, purchase of equipment including, but not limited to, wheelchairs and hospital-type beds.
- An initial lens per surgical eye directly related to cataract surgery (contact lens or framed lens).
- IUDs and diaphragms.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.

- Cochlear implants, as described in the Schedule of Benefits~~which includes the device, surgery for implantation of the device, and follow-up sessions to train on use of the device, covered at 80% as determined Medically Necessary by the Health Plan. Hospital charges for the surgery are covered at 100%. The annual out-of-pocket maximum for Durable Medical Equipmentdoes not apply to this benefit. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable at 100%~~.

- One hearing aid, as described in the Schedule ofBenefits~~per ear, no more than once every three years, as determined by the Health Plan to be Medically Necessary, covered at 80% up to a maximum payment of $1,000 per hearing aid~~. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold. ~~The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment. As required by Wis. Stat. §632.895 (16), hearing aids for Participants under 18 years of age are payable at 100% and the $1,000 limit does not apply.~~

- Ostomy and catheter supplies.

- Oxygen and respiratory equipment for home use when authorized by the Health Plan.

- Other medical equipment and supplies as approved by the Health Plan. Rental or purchase of equipment/supplies is at the option of the Health Plan.

- When Prior Authorized as determined by the Health Plan, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the Health Plan will consider whether: i) the equipment/supply is still useful or has exceeded its lifetime under normal use; or ii) the Participant's condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development). Services will be covered subject to ~~20% Coinsurance~~cost sharing as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual out-of-pocket maximum~~ for Durable Medical Equipment~~.

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

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

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

b. Outpatient mental health services and treatment of alcohol or drug abuse if the Dependent is a full-time student attending school in Wisconsin, but outside of the Plan Service Area, as required by Wis. Stat. 609.655. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider when Prior Authorized by the Health Plan. If outpatient services are recommended, coverage will be provided for five visits outside of the Plan's Service Area when Prior Authorized by the Health Plan. Additional visits may be approved by the Health Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to the limitations shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant.

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

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

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

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

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

Prescription drugs will be dispensed as follows:

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

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

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

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

expected and the complication requires Medically Necessary treatment that is performed by a Plan Provider or Prior Authorized by the Health Plan. The treatment of the complication must be a covered benefit of the Health Plan and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any plan in our program.

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

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

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

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

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

B. Limitations

1. Copayments or Coinsurance are required for:
   a. State of Wisconsin program Participants, except for retirees for whom Medicare is the primay payor, for all services unless otherwise required under federal and state law.
   ~~1.~~ b. State of Wisconsin Participants for whom Medicare is the primary payor, and for all Participants of the Wisconsin Public Employers program, and/or limitations apply to, the following services: Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.

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

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

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

Reduce Standard Plan benefits and modernize:

- *IX. Coordination Home Care, Home Care and Hospice Care Services, pages 20 and 21:* Reduce the home care benefit to align with Uniform Benefits, limit to 50 visits per year. Currently the benefit is two-pronged, with mandated and coordinated benefits available. This change would eliminate the coordinated benefit for coverage up to 365 days. This change will result in savings of $90,000

- *III. Schedule of Benefits, page 4:* Remove fourth quarter carry-over and common accident deductible provisions. These are now uncommon in the insurance industry. This change will result in savings of $50,000

- *IV. Standard Plan Hospital, Professional & Other Services, page 11:* Reduce the benefit for physical, speech and occupational therapies to match Uniform Benefits at 50 combined with an additional 50 per calendar year as approved by the plan. The current benefit has no visit limit and is subject only to medical necessity. This would result in a savings of approximately $3,500.

- *IV. Standard Plan Hospital, Professional & Other Services, page 12 & IX. Coordination Home Care, Home Care and Hospice Care Services, page 21:* Eliminate the benefit for home attendance care. This $1,500 lifetime benefit is rarely used and is unique to our program. In 2010 one member utilized it up to the maximum allowable amount.

- *IV. Standard Plan Hospital, Professional & Other Services, page 7:* Limit the extended care facility (skilled nursing facility) benefit to align with Uniform Benefits and eliminate the provision that states days are limited to double the number of unused hospital days, that is, up to 730 days. Staff recommends limiting this benefit to 120 days per benefit period as medically necessary. Since most care is rarely medically necessary after 120 days, WPS states that in 2010 this change would have saved the plan $600.

- *I. Definitions, page 2 and 3:* Clarify the benefits for office visits to allow for payment of services rendered in a convenient care clinic. The contract is silent on this, and the potential for such claims is growing as these types of clinics expand into Wisconsin. This should result in a small savings as the cost of care in these clinics is usually less than a regular physician's office.

Increase Standard Plan benefits and modernize:

- *IV. Standard Plan Hospital, Professional & Other Services, pages 15 and 16:* Modernize the contract to include a list of payable genetic services. The contract is silent and this creates barriers to authorizing medically necessary services. If made in 2010, this change would have resulted in an additional cost of $40,000.

- *IV. Standard Plan Hospital, Professional & Other Services, page 7:* Modernize inpatient hospital occupancy requirement from a semiprivate room or lesser accommodations and

remove the private room limitation since a number of hospitals no longer have two-bed rooms. In 2010 the current language saved the state $1,000, but required additional system manipulation by the administrator that lessened efficiency.

- *IV. Standard Plan Hospital, Professional & Other Services, page 11:* Modernize the plan by allowing for payment of dental claims related to cancer. These are: (a) extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and (b) sealants on existing teeth to prepare the jaw for chemotherapy treatment of neoplastic disease. This would add to the cost of the program by approximately $400 per incidence.

Modernization of Standard Plan items that have no impact on rates:

- *IV. Standard Plan Hospital, Professional & Other Services, page 7:* Staff recommends eliminating the 365 day hospital inpatient limit, and replacing it with language to align with Uniform Benefits, that is simply subject to medical necessity.

- *VIII. Transplantations, Implantations and Grafting, page 19:* Modernize the list of payable implants. The current list is out-of-date and creates barriers to authorizing medically necessary implants. This language would clarify existing practice.

- *I. Definitions, page 1:* Clarify the contract to permit WPS to allow additional savings from a third party network for surgical assistants, bilateral surgical procedures, and multiple procedures when they are greater than those stated in the contract. This language would clarify existing practice.

- *IV. Standard Plan Hospital, Professional & Other Services, page 11:* Eliminate the private duty nursing services language. The plan could authorize the care as alternate care if it was found to be more cost effective than other covered services, but the benefit would not explicitly be available.

- *IV. Standard Plan Hospital, Professional & Other Services, page 12:* Clarify the contract to permit WPS to allow for payment of outpatient cardiac rehabilitation services following hospital outpatient cardiac treatment. Currently, the contract states these services are payable only if the participant begins them immediately following a hospital confinement. Outpatient care is less costly, and this is becoming the standard of care. This language would clarify existing practice.

- *IV. Standard Plan Hospital, Professional & Other Services, page 16:* Clarify the contract to permit WPS to allow for payment of health and behavior assessments and neuropsychological testing provided by a psychologist to treat a physical illness or injury. These types of services are to treat specific issue such as a head injury, and are almost always performed only by psychologists. The current contract does not allow for a psychologist to bill such services with a medical diagnosis. It requires billing by a physician. This language would clarify existing practice.

- *IV. Standard Plan Hospital, Professional & Other Services, page 17:* Clarify the contract to exclude infertility services that are not for the treatment of illness or injury, and align with Uniform Benefits. The contract is currently silent and this was an

issue identified in the audit for clarification. This language would clarify existing practice.

- *VIII. Transplantations, Implantations and Grafting, page 18:* Clarify the transplant benefit to state that procurement and donor charges are included. This codifies existing practice.

- *IV. Standard Plan Hospital, Professional & Other Services, page 17:* Clarify the benefit for pain management to assist members in understanding the benefit. The contract is currently silent and this benefit is payable if it meets the administrator's medical policy.

- *XI. Exclusions E., page 22:* Clarify that refractive surgery is allowable if medically necessary to treat an illness or injury. Retain the exclusion for all other refractive surgery.

- *VIII. Transplantations, Implantations and Grafting, page 19: and XI. Exclusions, page 23:* Clarify the contract regarding medically necessary treatment for sexual dysfunction. The contract is currently silent and this benefit was identified as unclear in the audit.

- *IV. Standard Plan Hospital, Professional & Other Services, page 13:* Clarify the contract regarding diabetic supplies. This plan will pay if they are received from a durable medical equipment vendor. The pharmacy benefits manager pays for those provided by a pharmacy. The contract is currently silent and this was an issue identified in the audit for clarification.

Deductible, coinsurance and emergency room copay changes to the Standard Plan:

- *III. Schedule of Benefits, page 4:* Preferred Provider annual deductible increase to $200 single / $400 family from $100 / $200.

- *III. Schedule of Benefits, pages 5 and 6:* Coinsurance for Preferred Providers decreases to 90% from 100% and for Non-Preferred Providers to 70% from 80%.

- *III. Schedule of Benefits, page 6:* Preferred Provider annual Out-of-Pocket Limit increases to $800 single / $1,600 family from $100 / $200.

- *III. Schedule of Benefits, page 6:* Routine, preventive care services paid at 100% due to federal health care reform.

- *I. Definitions page 2, and III. Schedule of Benefits, pages 5 and 6*: Emergency room copay including definition of Copayment.

- *IV. Standard Plan Hospital, Professional & Other Services, pages 8, 9 and 10:* An update to the criteria for gastric bypass or bariatric surgery is included due to a change in WPS medical policy.

- *IV. Standard Plan Hospital, Professional & Other Services, pages 11, 13, and 14:* Routine, preventive care services paid at 100% due to federal health care reform.

CHARGE means an amount for a HEALTH CARE SERVICE provided by a HEALTH CARE PROVIDER that is reasonable, as determined by WPS, when taking into consideration, among other factors determined by WPS: (a)~~,~~ amounts charged by HEALTH CARE PROVIDERS for similar HEALTH CARE SERVICES when provided in the same general area~~ ~~; (b) WPS' methodology guidelines; (c) pricing guidelines of any third party responsible for pricing a claim; and (d) the negotiated rate determined by WPS in accordance with the applicable contract between WPS and a preferred provider~~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.

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

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

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

CONFINEMENT means the period starting with a PARTICIPANT'S admission on an INPATIENT basis (more than 24 hours) to a GENERAL HOSPITAL, SPECIALTY HOSPITAL, 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.

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

COPAYMENT: A specified dollar amount that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the PLAN.

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

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

DEPARTMENT means the Department of Employee Trust Funds.

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

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

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

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

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.

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.

Please Note: The provisions in the CONTRACT allow day and visit limit maximums for treatment of nervous or mental disorders and alcoholism and drug abuse. These provisions appear in the CONTRACT in Article IV. A. 2., 3., 4., .5, and C. 9.. These are currently suspended, and benefits will pay the same as any other illness pursuant to the Federal Mental Health Parity Act.

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 $~~1~~200.00 per PARTICIPANT, not to exceed $~~2~~400.00 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated in paragraph 2. will NOT be used to satisfy this annual DEDUCTIBLE amount.

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.

B. EMERGENCY ROOM COPAYMENT

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

~~B~~C. 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 ~~10~~90%, 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 ~~8~~70%, unless specifically stated otherwise in the PLAN, up to the annual out-of-pocket limit stated below.

3. **COINSURANCE for Independent Anesthesiologists.**
   After the PREFERRED PROVIDER annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at ~~10~~90% 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 PREFERRED PROVIDER annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at ~~10~~90% 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 emergency room COPAYMENT and PREFERRED PROVIDER annual DEDUCTIBLE amount stated above ~~is~~ are satisfied, BENEFITS are payable at ~~10~~90% 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.

6. **COINSURANCE for Routine Physical Examinations and Other Preventive Services Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER.**
As required by federal law, BENEFITS are payable at 100% of charges for routine physical examinations and other preventive services as stated in the PLAN when provided by a PREFERRED PROVIDER, without application of the DEDUCTIBLE amount.

D. 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~~800.00 per PARTICIPANT, not to exceed $~~2~~1,600.00 per family. This total is made up of the annual DEDUCTIBLE and COINSURANCE amounts for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a 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

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.

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

With respect to CONFINEMENTS for pregnancy, the PLAN shall not limit the length of stay to less than: (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 a maximum of 120 days per calendar year~~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.

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

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

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

(1) Within the past twelve months, there must be appropriate documentation of at least six consecutive months of ~~adherence~~ compliance with ~~to~~ a professionally supervised weight loss program. In cases where the PARTICIPANT is not compliant, this criterion for approval will be considered unmet). ~~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~~the primary service provided to the patient on that date; **OR**

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

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

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

~~**(2)** Eight week trial of pharmacotherapy (unless the pharmacotherapy is contraindicated)~~

(~~3~~2) Post bariatric surgery diet: Patient/program must meet one of the following:

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

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

(~~4~~3) A psychological evaluation that addresses and provides the necessary treatment for addiction and compliance concerns has been completed.

(~~5~~4) prior authorization is received from WPS.

(~~6~~5) there has been no previous bariatric surgery performed;

(~~7~~6) In addition to the criteria above, PARTICIPANTS with a five year history of BMI greater than 35, one of the following comorbid conditions must be documented:

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

(b) Type 2 diabetes without adequate control despite the use of appropriate medications ~~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) not responsive to a three-month trial of CPAP therapy.

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

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

b. BENEFITS are payable for a covered surgical procedure that requires a surgical assistant to be present, as determined by WPS, only as follows. If WPS determines BENEFITS are payable for the SERVICES directly provided to a PARTICIPANT by a surgical assistant: (1) BENEFITS for the covered services of a PHYSICIAN surgical assistant will be paid up to a maximum of 15% of the charge WPS determines for that surgical procedure performed by the PHYSICIAN; and (2) BENEFITS for the covered services of a surgical assistant who is not a PHYSICIAN will be paid up to a maximum of 10% of the CHARGE WPS determines for that surgical procedure performed by the PHYSICIAN.

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

d. BENEFITS payable for covered multiple surgical procedures, other than bilateral surgical procedures, are limited to a maximum of 100% of the CHARGE WPS determines for the primary surgical procedure and 50% of the CHARGE WPS determines for each additional procedure, other than procedures determined to be incidental or inclusive. A primary surgical procedure is the surgical procedure with the highest charge as determined by WPS. Multiple surgical procedures are more than one surgical or

12. Routine Physical Examinations.

BENEFITS are payable for routine physical examinations and related diagnostic services performed and billed by a PHYSICIAN as required by federal law. Physical examinations requested by a third party are not covered under this CONTRACT.

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

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

~~**14. 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.~~

14~~5~~. Dental SERVICES.

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

BENEFITS are also payable for:

a. HOSPITAL or ambulatory surgery center CHARGES incurred, and anesthetics provided, in conjunction with dental care that is provided to a PARTICIPANT in a HOSPITAL or ambulatory surgery center provided: (1) the PARTICIPANT is a child under the age of five; (2) the PARTICIPANT has a chronic disability that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or (3) the PARTICIPANT has a medical condition that requires hospitalization or general anesthesia for dental care;

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

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

17~~8~~. 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 a discharge from a 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 IMMEDIATE 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.~~

18~~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.

~~2~~19. Licensed Free-Standing Surgical Center.
BENEFITS are payable for CHARGES for facility fees for HEALTH CARE SERVICES provided in a licensed free-standing surgical center.

20~~2~~. 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.

When routine mammograms and pap smears are provided by a PREFERRED PROVIDER, BENEFITS are payable at 100% of the CHARGES, without application of the annual DEDUCTIBLE amounts.

21~~3~~. 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.

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

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

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

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

224. 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.

235. Blood Lead Tests.
BENEFITS are payable for CHARGES for blood lead tests for PARTICIPANTS age five and under. When such blood lead tests are provided by a PREFERRED PROVIDER, BENEFITS are payable at 100% of the CHARGES without application of the annual DEDUCTIBLE amounts.

246. 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.

257. 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.

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

a. Intrauterine devices (IUD);

b. Subdermal contraceptive implants;

c. Diaphragms;

d. Injections of medication for birth control.

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

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

30. Genetic Services.

BENEFITS are payable for charges for the following genetic services:

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

b. amniocentesis during pregnancy;

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

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

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

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

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

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

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

(1) Canavan Disease;

(2) Congenital Profound Deafness;

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

(4) Factor V Leiden Thrombophilia;

(5) Familial Adenomatous Polyposis Coli;

(6) Gaucher Disease;

(7) Hemoglobinopathies;

(8) Hereditary Hemochromatosis;

(9) Hereditary Non-Polyposis Colorectal Cancer;

(10) Long QT Syndrome;

(11) Mitochondrial Disorders;

(12) Myotonic Dystrophy;

(13) Niemann-Pick Disease;

(14) Retinoblastoma;

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

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

(17) Tay-Sachs Disease; or

(18) Von Hippel-Lindau Disease.

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

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

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

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

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

32. Infertility Services.

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

33. Pain Management Treatment.

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

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

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

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

c. facet joint injections and medical branch nerve blocks;

d. trigger point injections;

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

f. sacroiliac joint injections;

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

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

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.: Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill. Separately billed donor-related services are not covered under 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;

2. IMPLANTATIONS.
The following IMPLANTATIONS are covered by this CONTRACT:

a. Heart valve IMPLANTATION;

b. Pseudophakia (intraocular lens) IMPLANTATION;

~~**c.** Penile prosthesis IMPLANTATION;~~

~~**d.**~~c. Urethral sphincter IMPLANTATION;

~~**e.**~~d. Artificial breast IMPLANTATION;

e~~f~~. pacemaker;

f~~g~~. defibrillator;

g~~h~~. cochlear as required by Wis. Stat. §632.895 (16); and

h. for the STANDARD PLAN in Sections III and IV, all implant which WPS determines is medically necessary and not experimental.

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;

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.

This paragraph 1. does not apply to the STANDARD PLAN of Sections III and IV.

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.

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:

(a) 40 HOME CARE visits in any 12 month period per PARTICIPANT for other than the STANDARD PLAN in Sections III. and IV.; and

(b) 50 HOME CARE visits per calendar year per participant for the STANDARD PLAN in Sections III. and Section IV. 50 additional visits per PARTICIPANT per CALENDAR YEAR may be available if MEDICALLY NECESSARY and approved by WPS.

(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.**
This paragraph 3. does not apply to the STANDARD PLAN in Sections III and IV.

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 IMMEDIATE 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.

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, for medically necessary eye refractive surgeries covered under the STANDARD PLAN of Sections III and IV; 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. Routine periodic maintenance of covered DURABLE MEDICAL EQUIPMENT, such as, replacement batteries.

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

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

L. Over-the-counter drugs.

M. 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.

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

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

P. 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.

RR. Orthopedic shoes.

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