UNIFORM BENEFITS EXCERPTS – ATTACHMENT D

I. SCHEDULE OF BENEFITS

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

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

NOTE: - 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. Out-of-network deductible amounts do not accumulate to the in-network out-of-pocket limit.*

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

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

- Policy Coinsurance and medical Copayments: described below

Benefit	State of Wisconsin eligible Participants 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

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Annual Medical Coinsurance	90%/10% except as described below. Coinsurance applies to Out-of-Pocket-Limit (OOPL) except as described below.	100% except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.
Annual Medical Out-of-Pocket Limit (OOPL)	$500 Participant/$1,000 aggregate family limit except as described below.	None except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.
Routine, preventive services as required by federal law	100%	100%
Illness/injury related services	90% (10% member cost to OOPL)	100%
Emergency Room Copay (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	$75 does not accumulate to OOPL, after copay 90%. (10% member cost to OOPL)	$60
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% (20% member cost to OOPL)	80% to an annual OOPL of $500 per Participant; no aggregate family limit (20% member cost to OOPL)
Cochlear Implants for Participants age 18 and older	90% hospital charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).
Cochlear Implants Participants under age 18	As required by Wis. Stat. §632.895 (16), 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)	100% hospital, device, surgery for implantation and follow-up sessions to train on use.

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Hearing Aids for Participants age 18 and older. One aid per ear no more ~~than once every 3 years.~~per lifetime.	80% (20% member cost does not apply to OOPL) ~~Maximum health plan payment of $1,000 per hearing aid.~~	80% (20% member cost does not apply to OOPL) ~~Maximum health plan payment of $1,000 per hearing aid.~~

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

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- 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 as required by federal law. ~~, 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.

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- **HABILITATION SERVICES:** Means excluded health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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- **REHABILITATION SERVICES:** Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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- **SHARED DECISION MAKING (SDM):** Means a program offered by a Health Plan or health care provider that Participants must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform Participants about the range of options, outcomes, probabilities, and scientific uncertainties of available

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treatment options so that Participants can decide the best possible course of treatment. The Health Plan or health care provider will provide the Participant with written Patient Decisions Aids (PDAs) as part of the SDM program.

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3. Surgical Services

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

Prior Authorization is required for referrals to Orthopedists and Neurosurgeons associated directly or indirectly with the health plan for any participant who has not completed an optimal regimen of conservative care for Low Back Pain (LBP). Prior Authorization is not required for a Participant who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty referral.

Participants seeking surgical treatment of LBP must participate in a credible Shared Decision Making (SDM) program provided by the Health Plan or its contracted providers consistent with the Prior Authorization requirement.

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11. Outpatient Rehabilitation Physical, Speech and Occupation Therapy

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

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17. Treatment of Temporomandibular Disorders

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

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

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

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

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

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3. Medical Supplies and Durable Medical Equipment

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

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

- Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when Medically Necessary, and refitting of any existing prosthesis is not possible.
- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- Rental or, at the option of the Health Plan, purchase of equipment including, but not limited to, wheelchairs and hospital-type beds.
- An initial lens per surgical eye directly related to cataract surgery (contact lens or framed lens).
- IUDs and diaphragms.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.
- Cochlear implants, as described in the Schedule of Benefits.
- One hearing aid, as described in the Schedule of Benefits ~~The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.~~
- Ostomy and catheter supplies.
- Oxygen and respiratory equipment for home use when authorized by the Health Plan.

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

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

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1. Prescription Drugs

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

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

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

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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.

In most instances, claims for Medicare Part D immunizations, vaccinations and other prescription drugs, including costs to administer injections for Participants with Medicare Part D coverage, will be submitted to the PBM for adjudication even when the HEALTH PLAN or a contracted provider administers the injection. If the HEALTH PLAN or a contracted provider is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

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10. Durable Medical or Diabetic Equipment and Supplies

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

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

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

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k. Habilitation services and treatment, except as required by state law, including Wis. Stat. §§ 632.895 (5), (12m), and (16).

~~k.~~l. Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).

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a. Continuation Coverage

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1) If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

   i. First, the benefits of a plan covering the person as an employee, member, or subscriber or as a dependent of an employee, member, or subscriber.

   ii. Second, the benefits under the continuation coverage.

2) If the other plan does not have the rule described in subparagraph 1), and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

b. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

3. Coordination of Dental Benefits

The dental benefits under Uniform Benefits provided by a Health Plan are considered to be primary with regards to stand-alone or wrap-around dental plans that are approved by the Group Insurance Board and held by employees, annuitants, and continuants pursuant to Wis. Adm. Code Ins. 3.40 (9) (d).

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J. Grievance Process

All participating Health Plans and the PBM are required to make a reasonable effort to resolve members' problems and complaints. If You have a complaint regarding the Health Plan's and/or PBM's administration of these benefits (for example, denial of claim or Referral), You should contact the Health Plan and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, You may file a written Grievance with the Health Plan and/or PBM. Contact the Health Plan and/or PBM for specific information on its Grievance procedures.

If You exhaust the Health Plan's and/or PBM's Grievance process and remain dissatisfied with the outcome, You may appeal to the Department by completing a Department complaint form. You should also submit copies of all pertinent documentation including the written determinations issued by the Health Plan and/or PBM. The Health Plan and/or PBM will advise You of Your right to appeal to the Department within 60 days of the date of the final grievance decision letter from the Health Plan and/or PBM.

However, you may not appeal to the Department issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental treatment, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the Independent Review Organization process under Wis. Stat. § 632.835 and Wis. Adm. Code INS § 18.11. You may ~~also~~ request an independent review ~~per~~ pursuant to Wis. Stat. § 632.835 and

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Wis. Adm. Code § INS 18.11. In this event, You must notify the Health Plan and/or PBM of Your request. In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11, any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, you have no further right to administrative review once the Independent Review Organization decision is rendered.

K. Appeals To The Group Insurance Board

After exhausting the Health Plan's or PBM's Grievance process and review by the Department, the Participant may appeal the Department's determination to the Group Insurance Board, unless an Independent Review Organization decision that is final and binding has been rendered in accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental treatment, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the Independent Review Organization process under Wis. Stat. § 632.835 and Wis. Adm. Code INS § 18.11 ~~or whether a treatment or service is Experimental~~. These appeals are reviewed only to determine whether the Health Plan and/or PBM breached its contract with the Group Insurance Board.