

## I. SCHEDULE OF BENEFITS

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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.

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. Benefits administered by the PBM do not apply toward the deductible. After the deductible is met, Uniform Benefits are administered as outlined below.

**NOTE: For Participants enrolled in a Preferred Provider Plan (Patients 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.**

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

- Policy Deductible: **NONE**
- Policy Coinsurance: **100% of charges, except Aa**s described below
- Lifetime Maximum Benefit **On All Medical and Pharmacy Benefits: \$2,000,000 per Participant**
- Ambulance: **Paid in full Covered** as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: **NONE**
- Outpatient Physical, Speech and Occupational Therapy Maximum: **Paid in full Covered** up to 50 visits for all therapies combined per **contract calendar** year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be prior authorized by the Health Plan, up to a maximum of 50 visits per therapy per **contract calendar** year.
- Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Supplies Coinsurance: Payable at 80%. Out-of-pocket expense will not exceed \$500.00 annually per Participant.

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One hearing aid per ear no more than once every three years payable 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.

- 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%. 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.
- Home Care Benefits Maximum: 50 visits per Participant per contract calendar year. Fifty additional Medically Necessary visits per contract calendar year may be authorized by the Health Plan.
- Hospice Care Benefits: Paid in full Covered when the Participant's life expectancy is 6 months or less, as authorized by the Health Plan.
- Transplants: Limited to transplants listed in Benefits and Services Section, subject to a lifetime benefit of \$1,000,000 for transplants, including Preoperative and Postoperative Care.

~~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%. Hospital charges for the surgery are covered at 100%.~~

- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.
- Mental Health/Alcohol/Drug Abuse Services:

Outpatient Services:	<u>\$1,800 maximum per Participant per contract calendar year</u>
Transitional Services:	<u>\$2,700 maximum per Participant per contract calendar year</u>
Inpatient Services:	<u>30 days or \$6,300, whichever is less, per Participant per contract calendar year</u>

Maximum Benefit: The maximum benefit for inpatient, outpatient and transitional services is \$7,000 per Participant per contract calendar year.

The maximum is determined using the average amount paid to the pp providers by the Health Plan and excludes costs associated with diagnostic testing and prescription drugs. The benefit is not subject to Copayment.

**Note: Annual dollar maximums for mental health only services are suspended. However, day limit maximums do apply, if applicable.**

**Annual dollar maximums remain in force for treatment of alcohol and drug abuse. Any benefits paid during the year for mental health services will be applied toward the annual benefit maximum for alcohol and drug abuse treatment when determining whether benefits for alcohol and drug abuse treatment remain available.**

- Vision Services: One routine exam per contract calendar year. Non-routine eye exams are covered as Medically Necessary.
- 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 contract calendar year.
- Dental Services: No Coverage provided under Uniform Benefits. 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. (An inpatient stay is generally 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):

\$300 per individual or \$600 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: 20% per purchase, 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.

**NOTE: For Participants enrolled in a Preferred Provider Plan (Patients Choice) this Schedule of Benefits applies to services received from Plan Providers. Your Plan will provide you with a Schedule of Benefits that will show the level of benefits for services provided by Non-Plan Providers.**

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### II. DEFINITIONS

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

- **BED AND BOARD:** Means all Usual and Customary Hospital charges for: (a) Room and meals; and (b) all general care needed by registered bed patients.
- **BENEFIT PERIOD:** Means the total duration of Confinements that are separated from each other by less than 60 days.
- **BRAND NAME DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic drug classifications.
- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.
- **CONFINEMENT/CONFINED:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA residential center, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of your physician; and discharge therefrom, or (b) the time spent receiving Emergency Care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement.
- **CONGENITAL:** Means a condition which exists at birth.
- **COINSURANCE:** A specified percentage of the charges that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **COPAYMENT:** A specified dollar amount that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **CUSTODIAL CARE:** Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a plan 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. It shall not be considered Custodial Care if the Participant is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the plan physician, that the medical or surgical treatment will enable that person to live outside an institution.  
  
Custodial Care also includes rest cures, respite care, and home care provided by family members.
- **DEPENDENT:** Means the Subscriber's:
  - ▶ spouse

- ▶ unmarried children
- ▶ legal wards who become legal wards of the Subscriber prior to age 19, but not temporary wards
- ▶ adopted children and children placed for adoption as provided for in Wis. Stat. § 632.896. Adoptive children become Dependents when placed in the custody of the parent
- ▶ stepchildren
- ▶ grandchildren if the parent is a Dependent child. The Dependent grandchild will be covered until the end of the month in which the Dependent child turns age 18.

Dependent children must be dependent on the Subscriber (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a Dependent for federal income tax purposes, whether or not the child is claimed.

Children born outside of marriage become Dependents of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health and Family Services or the equivalent if the birth was outside of the State of Wisconsin. The Effective Date of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth.

A spouse and stepchildren cease to be Dependents at the end of the month in which a divorce decree is entered. Other children cease to be Dependents at the end of the calendar year in which they turn 19 years of age or cease to be Dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

1. Children age 19 or over who are full-time students, if otherwise eligible (that is, continues to be a Dependent for support and maintenance and is not married), cease to be Dependents:
  - ▶ at the end of the calendar year in which they cease to be full-time students or in which they turn age 25, whichever occurs first.
  - ▶ At the end of the month in which they cease to be Dependent for support or maintenance or marry, whichever occurs first.

Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Service, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools, intersession courses (for example, courses during winter break); night schools and student commitments after the semester ends, such as student teaching.

2. If otherwise eligible, children who are, or become, incapable of self-support because of a physical or mental disability which can be expected to be of long-continued or indefinite duration of at least one year or longer, continue to be, or resume their status of, Dependents regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible Dependent under this program in order to continue or resume coverage. The Health Plan will monitor mental or physical disability at least annually, but will only terminate coverage prospectively upon determining the Dependent is no longer so disabled, and will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

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3. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.
4. Legal Wards cease to be Dependents at the end of the month in which they cease to be wards.

Any Dependent eligible for benefits will be provided benefits based on the date of eligibility, not on the date of notification to the Health Plan and/or PBM.

- **DURABLE MEDICAL EQUIPMENT:** Means an item which can withstand repeated use and is, as determined by the Health Plan, primarily used to serve a medical purpose with respect to an Illness or Injury, generally not useful to a person in the absence of an Illness or Injury, appropriate for use in the Participant's home, and prescribed by a Plan Provider.
- **EFFECTIVE DATE:** The date, as certified by the Department of Employee Trust Funds and shown on the records of the Health Plan and/or PBM, on which the Participant becomes enrolled and entitled to the benefits specified in the contract.
- **ELIGIBLE EMPLOYEE:** As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.
- **EMERGENCY:** Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson to reasonably conclude that a lack of medical attention will likely result in any of the following:
  1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
  2. Serious impairment to the Participant's bodily functions.
  3. Serious dysfunction of one or more of the Participant's body organs or parts.

Examples of Emergencies are listed in Section III., A., 1., e.

- **EXPENSE INCURRED:** Means an expense at or after the time the service or supply is actually provided - not before.
- **EXPERIMENTAL:** The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a Participant's Illness or Injury that, as determined by the Health Plan and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that Illness or Injury for a Participant's Illness or Injury. The criteria that the Health Plan and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that Illness or Injury by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more

conventional methods of treating the Illness or Injury have been exhausted by the Participant; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

- **FORMULARY:** A list of prescription drugs, established by a committee of physicians and pharmacists, which are determined to be medically- and cost-effective. The PBM may require prior authorization for certain formulary and non-formulary drugs before coverage applies.
- **GENERIC DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.
- **GENERIC EQUIVALENT:** Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.
- **GRIEVANCE:** Means a written complaint filed with the Health Plan and/or PBM concerning some aspect of the Health Plan and/or PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.
- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during this ~~contract~~ **calendar** year.
- **HOSPICE CARE:** Means services provided to a Participant whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the Participant as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care **PP** provider approved by the Health Plan.
- **HOSPITAL:** Means an institution that:
  1. (a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, Injury and Illness; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses; or
  2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare **PP** provider; and (c) is accredited as a Hospital by the Joint Commission of Accreditation of Hospitals.

The term Hospital does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal Hospital.

- **HOSPITAL CONFINEMENT** or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a Hospital on the advice of a Plan Provider; or (b) receiving Emergency care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility.

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- **ILLNESS:** Means a bodily disorder, bodily Injury, disease, mental disorder, or pregnancy. It includes Illnesses which exist at the same time, or which occur one after the other but are due to the same or related causes.
- **IMMEDIATE FAMILY:** Means the Dependents, parents, brothers and sisters of the Participant and their spouses.
- **INJURY:** Means bodily damage that results directly and independently of all other causes from an accident.
- **MAINTENANCE THERAPY:** Means ongoing therapy delivered after an acute episode of an Illness or Injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Therapy" is made by the Health Plan after reviewing an individual's case history or treatment plan submitted by a therapist.
- **MEDICALLY NECESSARY:** A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care pPProvider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM: (1) consistent with the symptom(s) or diagnosis and treatment of the Participant's illness or Injury; (2) appropriate under the standards of acceptable medical practice to treat that Illness or Injury; (3) not solely for the convenience of the Participant, physician, Hospital or other health care pPProvider; (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.
- **MEDICARE:** Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
- **MEDICAID:** Means a program instituted pursuant to Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
- **MISCELLANEOUS HOSPITAL EXPENSE:** Means Usual and Customary Hospital ancillary charges, other than Bed and Board, made on account of the care necessary for an Illness or other condition requiring inpatient or outpatient hospitalization for which Plan Benefits are available under this Health Plan.
- **NATURAL TOOTH:** Means a tooth that would not have required restoration in the absence of a Participant's trauma or injury, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.
- **NON-EXPERIMENTAL:** Means: (a) any discrete and identifiable technology, regimen or modality regularly and customarily used to diagnose or treat Illness; and (b) for which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective.
- **NON-PARTICIPATING PHARMACY:** Means a pharmacy who does not have a signed agreement and is not listed on the most current listing of the PBM's provider directory of Participating Pharmacies.

- **NON-PLAN PROVIDER:** Means a **pP**rovider who does not have a signed **pP**articipating Provider agreement and is not listed on the most current edition of the Health Plan's professional directory of Plan Providers. Care from a **nN**on-**pP**lan **pP**rovider requires prior-authorization from the Plan unless it is an Emergency or Urgent Care.
- **NUTRITIONAL COUNSELING:** This counseling consists of the following services:
  1. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician
  2. Re-assessment and intervention (individual and group)
  3. Diabetes outpatient self-management training services (individual and group sessions)
  4. Dietitian visit
- **OUT-OF-AREA SERVICE:** Means any services provided to Participants outside the Plan Service Area.
- **PARTICIPANT:** The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.
- **PARTICIPATING PHARMACY:** A pharmacy who has agreed in writing to provide the services that are administered by the PBM and covered under the policy to Participants. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a Participant. The PBM agrees to give You lists of Participating Pharmacies.
- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.
- **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.
- **PLAN DEPENDENT:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.
- **PLAN PROVIDER:** A **pP**rovider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Participants. The **pP**rovider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a Participant. The Health Plan agrees to give You lists of affiliated **pP**roviders. Some **pP**roviders require Prior Authorization by the Health Plan in advance of the services being provided.
- **PLAN SERVICE AREA:** Specific zip codes in those counties in which the affiliated physicians are approved by the Health Plan to provide professional services to Participants covered by the Health Plan.

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- **POSTOPERATIVE CARE:** Means the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.
- **PREOPERATIVE CARE:** Means the medical evaluation of a Participant prior to a covered surgical procedure. It is the immediate preoperative visit in the Hospital or elsewhere necessary for the physical examination of the Participant, the review of the Participant's medical history and assessment of the laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.
- **PRIMARY CARE PROVIDER:** Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Health Plan's health care system. He/She also (a) evaluates the Participant's total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other **Provider** health services and refers the Participant to other Providers ~~of Health Care~~.

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

- **PRIOR AUTHORIZATION:** Means obtaining approval from your Health Plan before obtaining the services. Unless otherwise indicated by your Health Plan, Prior Authorization is required for care from **any** Non-Plan Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan and are described in Section G, Plan Descriptions, of the "It's Your Choice" book. Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.
- **PROVIDERS OF HEALTH CARE:** Means ~~(a) doctors, Hospitals, and clinics;~~ and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Plan Benefits.
- **REFERRAL:** When a Participant's Primary Care Provider sends him/her to another **Provider** for covered services. In many cases, the Referral must be in writing and on the Health Plan Prior Authorization form and approved by the Health Plan in advance of a Participant's treatment or service. Referral requirements are determined by each Health Plan and are described in Section G, Plan Descriptions, of the "It's Your Choice" book. The authorization from the health plan will state: a) the type or extent of treatment authorized; and b) the number of Prior Authorized visits and the period of time during which the authorization is valid. In most cases, it is the Participant's responsibility to ensure a Referral, when required, is approved by the Health Plan before services are rendered.
- **SCHEDULE OF BENEFITS:** The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the plan You elected.
- **SELF-ADMINISTERED INJECTABLE:** Means an injectable that is administered subcutaneously and can be safely self-administered by the PARTICIPANT and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intraarterial) injections or any drug administered through infusion.
- **SKILLED CARE:** Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving Skilled Care are usually quite ill

and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, "Skilled Care" is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require "Skilled Care" and are considered Custodial.

- **SKILLED NURSING FACILITY:** Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a Skilled Nursing Facility.
- **SPECIALTY MEDICATIONS:** Means medications that require special storage and handling and as a result, are more costly and usually not available from all Participating Pharmacies.
- **STATE:** Means the State of Wisconsin as the policyholder.
- **SUBSCRIBER:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.
- **URGENT CARE:** Means care for an accident or illness which is needed sooner than a routine doctor's visit. If the accident or injury occurs when during the Participant's is out of temporary absence from the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.
- **USUAL AND CUSTOMARY CHARGE:** An amount for a treatment, service or supply provided by a ~~non-plan health care provider~~ that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services prior to receiving services. Charges for Hospital or other institutional Confinements are incurred on the date of admission. All others are incurred on the date a Participant receives the service or item. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement. Health Plan approved Referrals to Non-Plan Providers are not subject to usual and customary charges. However, Emergency or urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges.
- **YOU/YOUR:** The Subscriber and his or her covered Dependents.

### **III. BENEFITS AND SERVICES**

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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 contract calendar year unless that provider left the 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. 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. Plan Hospital Emergency rooms should be used whenever possible. Should you be unable 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 are receiving 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. In addition to the emergency room Copayment, this out-of-plan Emergency care may be subject to Usual and Customary Charges.
- c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

- d. Emergency services include reasonable accommodations for repair of Durable Medical Equipment as Medically Necessary.
- e. Some examples of Emergencies are:
- ▶ Acute allergic reactions
  - ▶ Acute asthmatic attacks
  - ▶ Convulsions
  - ▶ Epileptic seizures
  - ▶ Acute hemorrhage
  - ▶ Acute appendicitis
  - ▶ Coma
  - ▶ Heart attack
  - ▶ Attempted suicide
  - ▶ Suffocation
  - ▶ Stroke
  - ▶ Drug overdoses
  - ▶ Loss of consciousness
  - ▶ Any condition for which you are admitted to the Hospital as an inpatient from the emergency room

## 2. Urgent Care

- a. Medical care received in an Urgent Care situation as defined in Section II. URGENT CARE IS NOT EMERGENCY CARE. It does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.
- b. You must receive Urgent Care from a Plan Provider if you are in the Plan Service Area, unless it is not reasonably possible. If you are out of the Plan Service Area, go to the nearest appropriate medical facility unless you can safely return to the Plan Service Area to receive care from a Plan Provider. If you must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where you received Urgent Care. ~~Out-of-plan~~ Urgent Care **from Non-Plan Providers** may be subject to Usual and Customary **e**Charges. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered.
- c. Some examples of Urgent Care cases are:
- ▶ Most Broken Bones
  - ▶ Minor Cuts
  - ▶ Sprains
  - ▶ Most Drug Reactions
  - ▶ Non-Severe Bleeding
  - ▶ Minor Burns

## 3. Surgical Services

Surgical procedures, wherever performed, when needed to care for ~~disease and accidental an~~ **Illness or** Injury. These include: (a) Preoperative and Postoperative Care; and (b) needed services of assistants and consultants.

### 4. Reproductive Services

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

- a. Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, Cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a daughter who is covered under this plan as a Participant. However, this does not extend coverage to the newborn who is not otherwise eligible (limited to if the Dependent daughter is age 18 or over at the time of birth). In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is Medically Necessary. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.
- b. Elective sterilization.
- c. Oral contraceptives, or cost-effective Formulary equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.
- d. IUDs , as described under the Durable Medical Equipment provision.
- e. Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

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

### 5. Medical Services

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

- a. Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.
- b. Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations ~~and other immunizations as Medically Necessary.~~
- c. Medically Necessary travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the Participant by the Health Plan. It does not apply to travel required for work. (See Exclusion A., 2., e.)
- d. Injectable and infusible medications, except for Self-Administered Injectable medications.
- e. Nutritional **eC**ounseling provided by a participating registered dietician or Plan Provider.

### **6. Anesthesia Services**

Covered when ~~they are~~ provided in connection with other medical and surgical services, ~~which are covered under this plan and performed by an approved Provider of Health Care~~. It will also include anesthesia services for dental care as provided under item B., 1., c., of this section.

### **7. Radiation Therapy**

Covered when accepted therapeutic methods, such as x-rays, radium and radioactive isotopes are administered and billed by an approved Provider ~~of Health Care~~.

### **8. Detoxification Services**

Covers Medically Necessary detoxification services provided by an approved Provider ~~of Health Care~~.

### **9. Ambulance Service**

Covers licensed professional ambulance service (or comparable Emergency transportation if authorized by the Health Plan) when necessary to transport to the nearest Hospital where appropriate medical care is available when the conveyance is an Emergency or Urgent in nature and medical attention is required en route, as described in the Schedule of Benefits. Ambulance services include Medically Necessary transportation and all associated supplies and services provided therein. If the Participant is not in the Plan's Service Area, the Health Plan or Plan Provider should be contacted, if possible, before Emergency or Urgent transportation is obtained. In most cases, medical attention should be received at the closest appropriate medical facility rather than returning to the Service Area for treatment.

### **10. Diagnostic Services**

Medically Necessary testing and evaluations, including, but not limited to, x-rays and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations.

### **11. Outpatient Physical, Speech and Occupation Therapy**

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

### **12. Home Care Benefits**

Care and treatment of a Participant under a plan of care. The Plan Provider must establish this plan; approve it in writing; and review it at least every two (2) months unless the physician determines that less frequent reviews are sufficient.

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

- a. Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

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

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

- 1) Hospital Confinement or Confinement in a Skilled Nursing Facility would be needed if home care were not provided.
- 2) The Participant's Immediate Family, or others living with the Participant, cannot provide the needed care and treatment without undue hardship.
- 3) A state licensed or Medicare certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

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

Home care benefits are limited to the maximum number of visits specified in the Schedule of Benefits, although up to 50 additional home care visits per contract-calendar year may be Prior Authorized by the Health Plan if the visits continue to be Medically Necessary and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating your needs or developing a plan counts as one visit. Each period of four (4) straight hours in a twenty-four (24) hour period of home health aide services counts as one home care visit.

### **13. Hospice Care**

Covers Hospice Care if the Primary Care Provider certifies that the Participant's life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the Health Plan. Hospice Care is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. Hospice Care includes, but is not limited to, medical supplies and services, counseling, bereavement counseling for 1 year after the Participant's death, Durable Medical Equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a 6-month period if authorized by the Health Plan.

**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 Replacement with Artificial Teeth Because of Accidental Injury**

Total extraction or total replacement (limited to, bridge or denture) of natural teeth by an approved Plan Provider when necessitated by an Injury. The treatment must commence within eighteen months of the accident. 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.

**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 when performed by an oral surgeon.
- b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.
- c. Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)
- d. Surgical procedures required to correct accidental injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such injuries are incurred while the Participant is continuously covered under this contract or a preceding contract provided through the Board.
- e. Apicoectomy. (Excision of apex of tooth root.)
- f. Excision of exostoses of the jaws and hard palate.
- g. Intraoral and extraoral incision and drainage of cellulitis.
- h. Incision of accessory sinuses, salivary glands or ducts.
- i. Reduction of dislocations of, and excision of, the temporomandibular joints.
- j. Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related medically necessary guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

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

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

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

### **17. Treatment of Temporomandibular Disorders**

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

- a. A Congenital, developmental or acquired deformity, disease or Injury caused the condition.
- b. The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care provider rendering the service.
- c. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, ~~including intraoral splint therapy~~, 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 ~~contract~~ calendar year.

### **18. Transplants**

The following transplantations are covered, however, all services, including transplant work-ups, must be Prior Authorized by the Health Plan in order to be a covered transplant. Donor expenses are covered when included as part of the Participant's (as the transplant recipient) bill. All transplant-related expenses, including Preoperative and Postoperative Care, are applied to the \$1,000,000 maximum lifetime benefit for transplants.

Limited to one transplant per organ per Participant per Health Plan during the lifetime of the policy, except as required for treatment of kidney disease. Organ retransplantation, which applies to items b., e., f., and g. as listed below, is not a covered benefit.

- a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
  - ▶ Aplastic anemia
  - ▶ Acute leukemia
  - ▶ Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies
  - ▶ Wiskott-Aldrich syndrome
  - ▶ Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

- ▶ Hodgkins and non-Hodgkins lymphoma
  - ▶ Combined immunodeficiency
  - ▶ Chronic myelogenous leukemia
  - ▶ Pediatric tumors based upon individual consideration
  - ▶ Neuroblastoma
  - ▶ Myelodysplastic syndrome
  - ▶ Homozygous Beta-Thalassemia
  - ▶ Mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
  - ▶ Multiple Myeloma, Stage II or Stage III
  - ▶ Germ Cell Tumors (e. g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound
- b. Parathyroid transplantation
- c. Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, Congenital anomalies or previous therapeutic processes.
- d. Corneal transplantation (keratoplasty) limited to:
- ▶ Corneal opacity
  - ▶ Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a Participant who cannot wear a contact lens;
  - ▶ Corneal ulcer
  - ▶ Repair of severe lacerations
- e. Heart transplants will be limited to the treatment of:
- ▶ Congestive Cardiomyopathy
  - ▶ End-Stage Ischemic Heart Disease
  - ▶ Hypertrophic Cardiomyopathy
  - ▶ Terminal Valvular Disease
  - ▶ Congenital Heart Disease, based upon individual consideration
  - ▶ Cardiac Tumors, based upon individual consideration
  - ▶ Myocarditis
  - ▶ Coronary Embolization
  - ▶ Post-traumatic Aneurysm
- f. Liver transplants will be limited to the treatment of:
- ▶ Extrahepatic Biliary Atresia
  - ▶ Inborn Error of Metabolism
    - Alpha -1- Antitrypsin Deficiency
    - Wilson's Disease
    - Glycogen Storage Disease
    - Tyrosinemia
  - ▶ Hemochromatosis
  - ▶ Primary Biliary Cirrhosis
  - ▶ Hepatic Vein Thrombosis
  - ▶ Sclerosing Cholangitis
  - ▶ Post-necrotic Cirrhosis, Hbe Ag Negative

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- ▶ Chronic Active Hepatitis, Hbe Ag Negative
  - ▶ Alcoholic Cirrhosis, abstinence for 12 or more months
  - ▶ Epithelioid Hemangioepithelioma
  - ▶ Poisoning
  - ▶ Polycystic Disease
- g. Kidney/pancreas, heart/lung, and lung transplants as determined to be Medically Necessary by the Health Plan.
- h. In addition to the above-listed diagnoses for covered transplants, the Health Plan may Prior Authorize a transplant for a non-listed diagnosis if the Health Plan determines that the transplant is a Medically Necessary and a cost effective alternate treatment.
- i. Kidney Transplants. See item 19. below.

### **19. Kidney Disease Treatment**

Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum-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 Therapy.

### **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.

### **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: ~~Paid in full~~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 twenty-four (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: **Paid in full 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 described in the Schedule of Benefits. Follow-up care received in an emergency room to treat the same Injury is also subject to the 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: **Paid in full 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 **PP** providers as defined and set forth under Wis. Stat. § 632.89 (1) (e).

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.

#### **c. Inpatient Services**

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

### d. Other

- 1) 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. The charges for such drugs will not be applied the maximum benefit available for any mental health, alcohol or drug abuse services.
- 2) The dollar amounts applied to the maximum benefits available for the treatment of mental health, alcohol, and drug abuse will be based upon the average amount paid to the pP provider by the Health Plan.

### **2. Durable Diabetic Supplies**

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider, durable diabetic equipment including insulin infusion pumps (limited to one pump in a calendar year and you must use the pump for thirty (30) days before purchase) and any supplies that are durable or disposable that are required for use with the durable diabetic equipment, will be covered after a 20% Coinsurance as outlined in the Schedule of Benefits. Automated injection devices are covered if Prior Authorized by the Health Plan. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for Durable Medical Equipment.

All Durable Medical Equipment purchases or monthly rentals that exceed \$200.00 must be Prior Authorized 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 for medical equipment after a Coinsurance as outlined in the Schedule of Benefits. All Durable Medical Equipment purchases or monthly rentals that exceed \$200.00 must be Prior Authorized by the Health Plan. The following supplies and equipment will be covered:

- 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 such as, but not limited to: wheelchairs, hospital-type beds, and artificial respiration equipment.
- Therapeutic contact lenses or an initial lens(es) per surgical eye, following cataract surgery.

- IUDs.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per ~~contract~~ calendar year.
- Cochlear implants, 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 Equipment does not apply to this benefit.
- One hearing aid, per ear, no more than once every three years, as determined by the Health Plan to be Medically Necessary, per ear every three years, 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 ~~does not apply to this benefit~~.
- Ostomy and catheter supplies.
- 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.
- Repairs, maintenance and replacement of covered Durable Medical Equipment/supplies if Prior Authorized by the Health Plan, 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).

#### **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. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider that the Health Plan designates. If outpatient services are recommended, coverage will be provided for five (5) visits outside of the Plan's Service Area. 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 dollar limitation shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant.

#### **5. Congenital Defects and Birth Abnormalities**

Pursuant to Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a Dependent is continuously covered under any plan under this health insurance program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to

achieve normal functioning. ~~If required by Wis. Statute, t~~This provision includes, ~~if as a secondary aspect of restoring functioning to the body part (that is,~~ orthodontia and dental procedures if necessary ~~as a secondary aspect of~~ for restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate).

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

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

If you do not show your PBM identification card at the pharmacy at the time you are obtaining benefits, you may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, you may be responsible for more than the Copayment amount. The PBM will determine the benefit amount based on the network price.

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

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

**1. Prescription Drugs**

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

An annual out-of-pocket 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 ~~contract~~ calendar year. Further, if participating family members combined have paid \$600 in a year, even if no one Participant has paid \$300 in Copayments, all family members will have satisfied the annual out-of-pocket maximum for that ~~contract~~ 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).

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 Section IV. Exclusions and Limitations 12. (b) for Participants in the Wisconsin Public Employers' group, 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:

- ▶ In maximum quantities not to exceed a ~~thirty (30)~~ consecutive day supply per Copayment.
- ▶ The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns).
- ▶ Single packaged items are limited to 2 items per Copayment or a ~~thirty (30)~~-day supply, whichever is more appropriate, as determined by the PBM.
- ▶ Oral Contraceptives are not subject to the ~~thirty (30)~~-day supply and will be dispensed at one Copayment per package or a 28-day supply, whichever is less.
- ▶ Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation (limited to, **generic Zyban equivalents**, nicotine inhaler, spray or patch). These **require a prescription from a physician and must be filled at a Participating Pharmacy. Only one 30-day supply of medication may be obtained at a time and is** ~~are~~ subject to the prescription drug Copayment and annual out-of-pocket maximum. **Coverage is** ~~limited~~ to a maximum of one consecutive three-month course of pharmacotherapy per calendar year.
- ▶ Prior Authorization from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring Prior Authorization is available from the PBM.
- ▶ Cost-effective Generic Equivalents will be dispensed unless the Plan Provider specifies the Brand Name Drug and indicates that no substitutions may be made, **in which case the Brand Name Drug will be covered at the Copayment specified in the Formulary.**
- ▶ Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Formulary prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two Copayments will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. Self-Administered Injectables and narcotics are among those for which a 90-day supply is not available.
- ▶ Tablet Splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 Formulary drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply (15 tablets – 30-day supply). Participants who use tablet splitting will pay half the normal Copayment amount.
- ▶ Generic sampling is available to encourage the use of Level 1 Formulary medications, whereby the PBM may waive the Copayment of a Level 1 Formulary prescription drug on

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the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.

- ▶ The PBM reserves the right to designate certain over the counter drugs on the Formulary.
- ▶ **Specialty Medications and** Self-Administered Injectables when obtained by prescription and which can safely be administered by the Participant, must be obtained from a PBM Participating Pharmacy or in some cases, the PBM may need to limit availability to specific pharmacies.

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

### **2. Insulin, Disposable Diabetic Supplies, Glucometers**

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

- a. Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a ~~thirty (30)~~ consecutive day supply for one prescription drug Copayment, as described on the Schedule of Benefits.
- b. Disposable Diabetic Supplies and Glucometers will be covered after a 20% Coinsurance as outlined in the Schedule of Benefits when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies including needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for prescription drugs.

### **3. Other Devices and Supplies**

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

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

## IV. EXCLUSIONS AND LIMITATIONS

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### A. Exclusions

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

#### 1. *Surgical Services*

- a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.
- b. 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.
- c. Any surgical treatment or Hospitalization for the treatment of obesity, including morbid obesity or as treatment for the comorbidities of obesity, for example, gastroesophageal reflux disease.
- d. Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

#### 2. *Medical Services*

- a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits section.
- b. Expenses for medical reports, including preparation and presentation.
- c. Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; (c) treatment of flexible flat feet; or (d) in connection with any of these except when prescribed by a Plan Provider who is treating the Participant for a metabolic or peripheral disease or if the skin or tissue is infected.
- d. Weight loss programs including dietary and nutritional treatment in connection with obesity.
- e. Work related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).

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- f. Services of a blood donor. Medically Necessary autologous blood donations are not considered to be services of a blood donor.
- g. Genetic testing and/or genetic counseling services, unless Medically Necessary to diagnose or treat an existing illness.

### **3. Ambulance Services**

- a. Ambulance service, except as outlined in the Benefits and Services section, unless authorized by the Health Plan.
- b. Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits Section.

### **4. Therapies**

- a. Vocational rehabilitation including work hardening programs.
- b. Maintenance Therapy. Examples include: physical, speech and occupational therapy and other special therapy except as specifically listed in the Benefits section.
- c. Therapies, as determined by the Health Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies ~~which~~ that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein.

These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction.

- d. Physical fitness or exercise programs.
- e. Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.
- f. Massage therapy.

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

- a. All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in the Benefits **and Services** Section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits Section. (Note: Under some circumstances, mandated TMJ benefits under Wis. Stat. § 632.895 (11) may supercede this benefit.)
- b. All periodontic procedures, except gingivectomy surgery as listed in the Benefits Section.

- c. All oral surgical procedures not specifically listed in the Benefits Section.

### **6. Transplants**

- a. Transplants and all related services, except those listed as covered procedures.
- b. Services in connection with covered transplants unless Prior Authorized by the Health Plan.
- c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.
- d. Purchase price of bone marrow, organ or tissue that is sold rather than donated.
- e. All separately billed donor-related services, except for kidney transplants.
- f. Non-human organ transplants or artificial organs.

### **7. Reproductive Services**

- a. Infertility services which are not for treatment of Illness or Injury (i.e., which are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an Illness.
- b. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.
- c. **Services for storage or processing of semen (sperm); donor sperm.**
- d. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related Hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.
- e. Implantable birth control devices (for example, Norplant).
- f. Surrogate mother services.
- g. Maternity services received out of the Plan Service Area in the ninth month of pregnancy, unless Prior Authorized (Prior Authorization will be granted only if the situation is out of the Participant's control (for example, family emergency)).
- h. Amniocentesis or chronic villi sampling (CVS) solely for sex determination.

### **8. Hospital Inpatient Services**

- a. Take home drugs and supplies dispensed at the time of Hospital discharge, which can reasonably be purchased on an outpatient basis.
- b. Hospital stays, which are extended for reasons other than Medical Necessity, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.
- c. A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, Skilled Nursing Facility.

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### **9. Mental Health Services/Alcohol and Drug Abuse**

- a. Hypnotherapy.
- b. Marriage counseling.
- c. Residential care except transitional care as required by Wis. Stat. § 632.89.
- d. Biofeedback.

### **10. Durable Medical or Diabetic Equipment and Supplies**

- a. All Durable Medical Equipment purchases or rentals per month exceeding \$200 unless authorized by the Health Plan.
- b. Repairs and replacement of Durable Medical Equipment/supplies unless Prior 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; and self-help devices not medical in nature.
- d. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as Prior Authorized by the Health Plan.
- e. Equipment, models or devices ~~which that~~ have features over and above that which are Medical  Necessary for the Participant will be limited to the standard model as determined by the Health Plan.
- f. Oxygen therapy and other inhalation therapy and related items for home use except as authorized by the Health Plan.
- g. Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.
- h. Customization of buildings for accommodation (for example, wheelchair ramps).

### **11. Outpatient Prescription Drugs – Administered by the PBM**

- a. Charges for supplies and medicines ~~you buy~~ with or without a doctor's prescription, unless otherwise specifically covered.
- b. Charges for prescription drugs which require Prior Authorization unless approved by the PBM.
- c. Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent .
- d. Any medications specifically prescribed for weight loss (for example, appetite suppressants) .
- e. Anorexic agents.

- f. Non-FDA approved prescriptions, including compounded estrogen, oral progesterone or testosterone products, except as authorized by the PBM.
- g. All over the counter drug items, except ~~nicotinic acid and~~ those designated as covered by the PBM.
- h. Unit dose medication, ~~which includes~~ bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.
- i. Charges for injectable medications, except for Self-Administered Injectable medications.
- j. Charges for supplies and medicines purchased from a Non-Network Pharmacy, except when Emergency or Urgent Care is required.
- k. Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.
- l. Infertility and fertility medications.
- m. Charges for medications obtained through a discount program or over the Internet, unless Prior Authorized by the PBM.
- n. Charges for spilled, stolen or lost prescription drugs.

## **12. General**

- a. Any additional exclusion as described in the Schedule of Benefits.
- b. Except for benefits payable under Medicare Part D, services to the extent the Participant is eligible for all other Medicare benefits, regardless of whether or not the Participant is actually enrolled in Medicare. This exclusion only applies if Medicare is the primary payor.
- c. Treatment, services and supplies: ~~(a)~~ for which the Participant (a) has no obligation to pay or which would be furnished to a Participant without charge; (b) ~~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 (c) ~~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.
- d. Injury or Illness caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.
- e. Treatment, services and supplies for any Injury or Illness as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any State of the United States, or its Allies, or while serving in the Armed Forces of any country.
- f. Treatment, services and supplies furnished by the U.S. Veterans Administration, except for such treatment, services and supplies for which under the policy the Health Plan and/or PBM is the primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.

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- g. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- h. Treatment, services or supplies used in educational or vocational training.
- i.- Treatment or service in connection with any Illness or Injury caused by a Participant (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.
- j.- Care provided to assist with activities of daily living (ADL).
- k. Personal comfort or convenience items such as in-Hospital television, telephone, private room, housekeeping, shopping, and homemaker services, and meal preparation services as part of home health care.
- l. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the Plan.
- m. Custodial, nursing facility (except skilled), or domiciliary care. This includes community re-entry programs.
- n. Expenses incurred, or inpatient Confinements ~~which that~~ begin prior to the coverage Effective Date in the Health Plan and/or PBM, or services received after the Health Plan and/or PBM coverage or eligibility terminates. Except when a Participant's coverage terminates because of subscriber cancellation or non-payment of premium, benefits shall continue to the Participant if he or she is Confined as an inpatient on the coverage termination date but only until the attending physician determines that Confinement is no longer Medically Necessary; the contract maximum is reached; the end of 12 months after the date of termination; or Confinement ceases, whichever occurs first. If the termination is a result of a subscriber changing plans during a prescribed enrollment period as determined by the Board, benefits will continue unless the facility in which the participant is confined is not part of the succeeding plan's network. In this instance, the liability will remain with the previous insurer.
- o. Eyeglasses ~~and~~ or corrective contact lenses, fitting of contact lenses, except for ~~one~~ the initial lens per surgical eye ~~after~~ following cataract surgery.
- p. Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and Medically Necessary or not required in accordance with accepted standards of medical, surgical or psychiatric practice.
- q. Charges for any missed appointment.
- r. Experimental services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the Health Plan and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants.

In general, any service considered to be Experimental, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9).

- s. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.
- t. Services, including non-physician services, provided by Non-Plan Providers ~~of Health Care~~. Exceptions to this exclusion:
  - 1) On written Referral by Plan Provider with the prior written authorization of the Health Plan.
  - 2) Emergencies in the Service Area when the Primary Care Provider or another Plan Provider cannot be reached.
  - 3) Emergency or Urgent Care services outside the Service Area. Non-urgent follow-up care requires Prior Authorization from the Health Plan.
- u. Services of a specialist without a Plan Provider's written Referral, except in an Emergency or by written Prior Authorization of the Health Plan. Any Hospital or medical care or service not provided for in this document unless authorized by the Health Plan.
- v. Coma Stimulation programs.
- w. Orthoptics (Eye exercise training) except for two sessions as Medically Necessary per lifetime. The first session for training, the second for follow-up.
- x. Any diet control program, treatment, or supply for weight reduction.
- y. Food or food supplements except when provided during a covered outpatient or inpatient Confinement.
- z. Services to the extent a Participant receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation act, employer's liability insurance plan or similar law or act. Entitled means you are actually insured under Worker's Compensation.
- aa. Services related to an Injury that was self-inflicted for the purpose of receiving Health Plan and/or PBM Benefits.
- ab. Charges directly related to a non-covered service, such as hospitalization charges. Medically Necessary treatment of a complication that could not be reasonably expected is covered when performed by a Plan Provider or when authorized by the Health Plan in Emergency situations or when the original treatment or service was covered and paid for under any plan in our program. The treatment of the complication must be a covered benefit of the Health Plan and PBM.
- ac. Any inpatient Confinement that begins prior to the Participant's initial enrollment under the Board's program is not covered. Such inpatient Confinement will not be covered under any subsequent plan in which the Participant becomes enrolled.

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

ae. 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.

**af. Sexual counseling services related to infertility and sexual transformation.**

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

### B. Limitations

1. Copayments or Coinsurance are required for, and/or limitations apply to, the following services: Outpatient Services/Mental Health Services/Alcohol and Drug Abuse, Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders, ~~Ambulance transportation~~ 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-~~Network~~** Pharmacies.
5. Circumstances Beyond the Health Plan's and/or PBM's Control: If, due to circumstances not reasonably within the control of the Health Plan and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the Health Plan and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the Health Plan, Plan Providers and/or PBM will use their best efforts to provide services and other Benefits covered hereunder. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.
6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a Plan Provider for determining the need for correction.
7. Outpatient Physical, Occupational, Speech and Rehabilitation Therapy: These therapies are benefits only for treatment of those conditions which, in the judgment of the attending

physicians, are expected to yield significant patient improvement within two months after the beginning of treatment.

~~8. Sexual Counseling Services: Limited to those techniques commonly used by Plan Providers and for conditions producing significant physical and mental symptoms.~~

89. Lifetime policy maximum for transplant benefits: \$1,000,000.

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

910. Lifetime maximum benefits under this policy: \$2,000,000 (includes transplant benefits).