It's Your Choice
Local Access Deductible
Health Plan

Health Care Benefit Plan

WISCONSIN GROUP INSURANCE BOARD

DEPARTMENT OF EMPLOYEE TRUST FUNDS
P.O. Box 7931
801 West Badger Road
Madison, Wisconsin 53707-7931

ET-2131 (REV 8/2016)

GENERAL INFORMATION ABOUT YOUR PLAN

The STANDARD Group Health Insurance Plan is available to State of Wisconsin EMPLOYEES, ANNUITANTS, and their eligible DEPENDENTS, regardless of residence. All medical expenses covered under your PLAN as described in this booklet are paid for by The State of Wisconsin. This Plan is administered by Wisconsin Physicians Service Insurance Corporation (WPS) under an agreement between The State of Wisconsin and WPS.

All SERVICES should be provided by a PREFERRED PROVIDER in order to result in the lowest out-of-pocket cost to you.

The PLAN reserves the right to modify the list of PREFERRED PROVIDERS at any time, but will honor the selection of any provider listed in the current provider directory for the duration of that CALENDAR YEAR unless that provider left the 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). A PARTICIPANT who is in her second or third trimester of pregnancy may continue to have access to her PREFERRED PROVIDER until the completion of post-partum care for herself and the infant.

This booklet is devoted to STANDARD PLAN BENEFITS and highlights the provisions of the Plan. Be sure to familiarize yourself with its contents, and keep it in a safe place where you can refer to it quickly when you need it.

Alternate HEALTH CARE PLANS are also available in specific limited geographical areas. Those plans are generally known as Health Maintenance Organizations (HMOs) and actually compete against the STANDARD PLAN in cost, service and BENEFIT level. Before making an enrollment decision, all PLANS operating in your locality should be investigated so the PLAN most appropriate to your needs is selected.

In the event of a conflict between the CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

There has been some confusion about preauthorization and pre-certification in the past. The following information is intended to help you understand the requirements.

Preauthorization – while you are not required to obtain preauthorization for any outpatient services, if you are concerned as to whether your service will be payable and at what cost, a preauthorization is recommended.

Pre-certification – to avoid a potential benefit reduction on inpatient services, you, a family member, or a provider must notify WPS about any emergency or non-emergency inpatient hospitalization to request pre-certification of services.

Estimation of Out-of-Pocket Expenses (WI ACT 146) – At the written request of our PARTICIPANTS, WPS will provide a good faith estimate of the reimbursement that the PLAN will expect to

pay and the PARTICIPANT'S responsibility (out-of-pocket costs) for a specified health care service that is being considered. Note: This process does not take the place of a preauthorization, prior approval or precertification.

Further information appears in this benefit booklet under the Preauthorization and WPS Medical Management Care Program sections.

Other information of which you must be aware is contained in two brochures titled "It's Your Choice". Those brochures compare BENEFITS of STANDARD, SMP and all available HMOs and covers the following:

- Cancellation
- Change in family status
- Claims
- Complaint process
- Conversion
- Continuation of coverage after loss of eligibility
- Coordination of benefits
- Coverages
- Dependents
- Discharge
- Effective date
- Eligibility
- Enrollment
- ID Cards
- Late enrollment
- Layoff
- Leave of absence
- Payroll deductions
- Pharmacy Benefit Manager
- Retirement
- State contribution toward premium
- Surviving spouse/dependent

If you have specific questions pertaining to coverage, please contact WPS at 1-800-634-6448. You can also visit us at the following locations:

WPS - Madison Office
1717 West Broadway
Madison, Wisconsin 53713

WPS – Green Bay Office
421 Lawrence Drive, Suite 201
DePere, Wisconsin 54115

WPS - Eau Claire Office
2519 N. Hillcrest Parkway, Suite 200
Altoona, Wisconsin 54720

WPS - Milwaukee Office
20800 Swenson Drive, Suite 450
Waukesha, Wisconsin 53186

WPS - Wausau Office
1800 W. Bridge Street, Suite 200
Wausau, Wisconsin 54401

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DEFINITIONS

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

ACTIVITIES OF DAILY LIVING (ADL) means the following, whether performed with or without assistance:

1. Bathing which is the cleansing of the body in either a tub or shower or by sponge bath;

2. Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;

3. Toileting which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;

4. Mobility, which is to move from one place to another, with or without assistance of equipment;

5. Eating, which is getting nourishment into the body by any means other than intravenous; and

6. Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

ADVANCE CARE PLANNING means a process across time of understanding, reflecting on and discussing future medical decisions, including end-of-life preferences. Advance care planning includes:

1. Understanding a PARTICIPANT'S health care treatment options;

2. Clarifying a PARTICIPANT'S health care goals;

3. Weighing a PARTICIPANT'S options about what kind of care and treatment he/she would want;

4. Making decisions about whether a PARTICIPANT wants to appoint a health care agent and/or complete an advance directive;

5. Communicating a PARTICIPANT'S wishes and any documents with his/her family, friends, clergy, physician and other health care professionals.

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

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

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

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

ANNUITANT means any retired EMPLOYEE of the State of Wisconsin who: (1) is receiving an immediate annuity under the Wisconsin Retirement System; or (2) is an EMPLOYEE who retires after 20 years of creditable service; (3) is receiving a long-term disability benefit under Wis. Adm. Code § 50.40; or (4) is receiving a disability benefit under Wis. Stats. § 40.65.

BENEFITS mean a PARTICIPANT'S right to payment for covered HEALTH CARE SERVICES that are available under the PLAN. A PARTICIPANT'S right to BENEFITS is subject to the terms, conditions, limitations and exclusions of the PLAN.

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

BOARD means the Group Insurance Board.

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

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

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

CHARGE means an amount for a HEALTH CARE SERVICE provided by a HEALTH CARE PROVIDER that is reasonable, as determined by WPS, when taking into consideration, among other factors determined by WPS: (a) amounts charged by HEALTH CARE PROVIDERS for similar HEALTH CARE SERVICES when provided in the same general area under similar or comparable circumstances; (b) WPS' methodology guidelines; (c) pricing guidelines of any third party responsible for pricing a claim; and (d) the negotiated rate determined by WPS in accordance with the applicable contract between WPS and a preferred provider. The term "area" means a county or other geographical area which WPS determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. In some cases the amount WPS determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the HEALTH CARE SERVICE. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

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

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

COINSURANCE means a specified percentage of the charges that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the Schedule of Benefits.

CONFINEMENT means: (1) 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 a physician; and discharge therefrom, or (2) the time spent receiving EMERGENCY CARE for ILLNESS or INJURY in a HOSPITAL. 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.

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

CONVENIENT CARE CLINIC means a medical clinic that: (1) is located in a retail store, supermarket, pharmacy or other non-traditional, convenient, and accessible setting; and (2) provides covered HEALTH CARE SERVICES performed by nurse practitioners, physician assistants or physicians acting within the scope of their respective licenses.

COPAYMENT means the portion of the CHARGE for a covered expense that a PARTICIPANT is required to pay to the HEALTH CARE PROVIDER for a certain HEALTH CARE SERVICE covered under the PLAN. COPAYMENTS are a specific dollar amount. Please note that for covered HEALTH CARE SERVICES, the PARTICIPATING is responsible for paying the lesser of the following: (1) the applicable COPAYMENT; or (2) the covered expense.

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

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

DEPARTMENT means the Department of Employee Trust Funds.

DEPENDENT means, as provided herein, the SUBSCRIBER'S:

1. Spouse;

2. DOMESTIC PARTNER, if elected;

3. Child;

4. Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or covered DOMESTIC PARTNER prior to age 19;

5. Adopted child when placed in the custody of the parent as provided by Wis. Stats. § 632.896;

6. Stepchild;

7. Child of the DOMESTIC PARTNER covered under the PLAN;

8. Grandchild if the parent is a dependent child.

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

A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment. A DOMESTIC PARTNER and his or her child cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

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

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

2. After attaining age 26, as required by Wis. Stat. § 632.885, a DEPENDENT includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Children and Families (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity or a court order is filed within 60 days of the birth.

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

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

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

1. Each individual is at least 18 years old and otherwise competent to enter into a contract;

2. Neither individual is married to, or in a domestic partnership with, another individual;

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

4. The two individuals consider themselves to be members of each other's IMMEDIATE FAMILY;

5. The two individuals agree to be responsible for each other's basic living expenses; and

6. The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

a. Only one of the individuals has legal ownership of the residence;

b. One or both of the individuals have one or more additional residences not shared with the other individual;

c. One of the individuals leaves the common residence with the intent to return.

DURABLE MEDICAL EQUIPMENT means an item that WPS determines meets all of the following requirements:

1. It can withstand repeated use;

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

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

4. It is appropriate for use in the PARTICIPANT'S home;

5. It is prescribed by a PHYSICIAN.

6. It is medically necessary.

DURABLE MEDICAL EQUIPMENT includes, but is not limited to: wheelchairs; oxygen equipment (including oxygen); and hospital-type beds.

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

EMERGENCY MEDICAL CARE means HEALTH CARE SERVICES directly provided by a HEALTH CARE PROVIDER to treat a PARTICIPANT'S medical emergency. A medical emergency is a medical condition that involves acute and abnormal symptoms of such sufficient severity (including severe pain) to lead a prudent sensible who possesses an average knowledge of health and medicine would reasonably conclude that a lack of immediate 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.

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

EMPLOYER means the employing State agency or participating local government.

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

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

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

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

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

EXPERIMENTAL/INVESTIGATIVE/UNPROVEN means the use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT's ILLNESS or INJURY that, as determined by WPS's Corporate Medical Director:

1. Has not been approved by the appropriate federal or other governmental agency at the time the CHARGES were incurred; or

2. Isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT's ILLNESS or INJURY.

The criteria that WPS 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:

1. Whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis;

2. 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;

3. The failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply;

4. Whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT;

5. Whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated;

6. 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.

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

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

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

1. A convalescent or LICENSED SKILLED NURSING FACILITY unit within or affiliated with the HOSPITAL;

2. A clinic;

3. A nursing, rest or convalescent home, or LICENSED SKILLED NURSING FACILITY;

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

5. A sub-acute care center, health resort, spa or sanitarium.

GENETIC TESTING means examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

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

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

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

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

HEALTH BENEFIT PLAN/PLAN means the part of this CONTRACT that provides BENEFITS for HEALTH CARE SERVICES.

HEALTH CARE PROVIDER means any physician, hospital, pharmacy, clinic, skilled nursing facility, surgical center or other person, institution or other entity licensed by the state in which he/she is located to provide HEALTH CARE SERVICES.

HEALTH CARE SERVICES means diagnosis, TREATMENT, services, procedures, drugs, medicines, devices, or supplies directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER acting within the scope of his/her/its license.

HEARING AID means any externally wearable instrument or device designed for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except batteries and cords.

HOME CARE means HEALTH CARE SERVICES provided directly to a PARTICIPANT in his/her home under a written plan that meets the following criteria: (1) the plan is developed by the PARTICIPANT'S attending physician; (2) the plan is approved by the PARTICIPANT'S attending PHYSICIAN in writing; (3) the plan is reviewed by the PARTICIPANT'S attending PHYSICIAN every two months (or less frequently if the PARTICIPANT'S PHYSICIAN believes and WPS agrees that less frequent reviews are enough); and (4) home care is provided or coordinated by a home health agency or certified rehabilitation agency that is licensed by the Wisconsin Department of Health Services or certified by Medicare.

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

HOSPITAL means a GENERAL HOSPITAL and a SPECIALTY HOSPITAL.

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

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

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

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

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

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

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

INCIDENTAL/INCLUSIVE means a procedure or SERVICE is INCIDENTAL/INCLUSIVE if it is integral to the performance of another SERVICE or if it can be performed at the same time as another HEALTH CARE SERVICE without adding significant time or effort to the other HEALTH CARE SERVICE.

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

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

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

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

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

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

MEDICALLY NECESSARY means a HEALTH CARE SERVICE or facility that WPS determines to be:

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

2. Appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY; and

3. Not solely for the convenience of the PARTICIPANT, PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER; and

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

A HEALTH CARE SERVICE or facility may not be considered medically necessary even if the HEALTH CARE PROVIDER has performed, prescribed, recommended, ordered, or approved the SERVICE, or if the SERVICE is the only available procedure or TREATMENT for the PARTICIPANT'S condition.

MEDICAL SERVICES means HEALTH CARE SERVICES recognized by a PHYSICIAN to treat a PARTICIPANT'S ILLNESS or INJURY.

MEDICAL SUPPLIES means items that WPS determined to be:

1. Used primarily used to treat an ILLNESS or INJURY;

2. Generally not useful to a person in the absence of an ILLNESS or INJURY;

3. The most appropriate item that can safely be provided to a PARTICIPANT and accomplish the desired end result in the most economical manner;

4. Not primarily for the patient's comfort or convenience; and
5. Prescribed by a PHYSICIAN.

MISCELLANEOUS HOSPITAL EXPENSES means the regular HOSPITAL costs (including take-home drug expenses) that are covered under the PLAN for TREATMENT of an ILLNESS or INJURY requiring either: (1) inpatient hospitalization; or (2) outpatient HEALTH CARE SERVICES at a HOSPITAL. For outpatient HEALTH CARE SERVICES, MISCELLANEOUS HOSPITAL EXPENSES include CHARGES for: (1) use of the HOSPITAL'S emergency room; and (2) EMERGENCY MEDICAL CARE provided to a PARTICIPANT at the HOSPITAL. MISCELLANEOUS HOSPITAL EXPENSES do not include room and board, nursing services, and ambulance services.

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

NERVOUS OR MENTAL DISORDERS means clinically significant psychological syndromes that: (1) are associated with distress, dysfunction or physical illness; and (2) represent a dysfunctional response to a situation or event that exposes you to an increased risk of pain, suffering, conflict, physical illness or death. Behavior problems, learning disabilities or developmental delays are not nervous or mental disorders.

NON-PREFERRED PROVIDER means a health care provider that has not entered into a written agreement with the health care network selected by the SUBSCRIBER.

NURSE PRACTITIONER means an individual who is licensed as a registered nurse under Chapter 441, Wisconsin Statutes, as amended, or the laws and regulations of another state and who satisfies any of the following: (1) is certified as a primary care nurse practitioner or clinical nurse specialist by the American Nurses/ Association or by the National Board of Pediatric Nurse Practitioners and Associates; (2) holds and master's degree in nursing from an accredited school of nursing; (3) prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least four months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate

to individuals who successfully complete the program; or (4) has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of (3) above, and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

OFFICE VISIT means either of the following:

1. For HEALTH CARE SERVICES other than behavioral health services, a meeting between a PARTICIPANT and a PHYSICIAN or other HEALTH CARE PROVIDER that: (a) occurs at the provider's office, a medical clinic, CONVENIENT CARE CLINIC, an ambulatory surgical center, a free-standing urgent care center, SKILLED NURSING FACILITY, or the outpatient department of a HOSPITAL, other than a HOSPITAL'S emergency room; and (b) includes the PARTICIPANT receiving medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology or as determined by WPS) or manipulations by a PHYSICIAN, other than SERVICES related to physical therapy.

2. For behavioral health services, a meeting between a PARTICIPANT and a licensed psychiatrist, a licensed or certified PSYCHOLOGIST, or a HEALTH CARE PROVIDER licensed to provide nonresidential services for the TREATMENT of NERVOUS OR MENTAL DISORDERS, alcoholism or drug abuse that: (a) occurs in the provider's office, a medical clinic, a free-standing urgent care center, SKILLED NURSING FACILITY, outpatient treatment facility or the outpatient department of a HOSPITAL, other than a HOSPITAL'S emergency room; and (b) involves the PARTICIPANT receiving psychotherapy, psychiatric diagnostic interviews, medication management, electro-shock therapy, behavioral counseling, or neuropsychological testing.

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

OTHER COVERAGE means any group or franchise contract, policy, plan or program of prepaid service care or insurance arranged through any employer, trustee, union or association including, but not limited to, disability, health and accident or sickness care coverage, or the medical payments provisions of an automobile insurance policy, any or all of which would provide BENEFITS for medical care of any nature either on a service or expense incurred basis if this CONTRACT was not in effect.

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

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

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

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

PHYSICIAN means a person who:

1. Received one of the following degrees in medicine from an accredited college or university: Doctor of Medicine (M.D.); Doctor of Osteopathy (D.O); Doctor of Dental Surgery (D.D.S); Doctor of Dental Medicine (D.D.M.); Doctor of Surgical Chiropody (D.S.C.); Doctor of Podiatric Medicine (D.P.M.); Doctor of Optometry (O.D.); or Doctor of Chiropractic (D.C.);

2. Is a medical doctor or surgeon licensed by the state in which he/she is located; and

3. Practices medicine within the lawful scope of his/her license.

When required by law to cover the HEALTH CARE SERVICES of any other licensed medical professional under the PLAN, a PHYSICIAN also includes such other licensed medical professional who:

1. Is licensed by the state in which he/she is located;

2. Is acting within the lawful scope of his/her license; and

3. Provides a health care service that we determine to be a covered expense under the PLAN.

PLACED FOR ADOPTION means any of the following:

1. The Wisconsin Department of Children and Families, a county department under Wis. Stat § 48.57(1)(e) or (hm), or a child welfare agency licensed under § 48.60 places a child in a SUBSCRIBER'S home for adoption and enters into an agreement under § 48.63 (3) (b) 4. Or § 48.833 (1) or (2) with the SUBSCRIBER;

2. The Wisconsin Department of Children and Families, a county department under Wis. Stat. § 48.57 (1) (e) or (hm), or a child welfare agency under § 48.837(1r) places, or a court under § 48.837 (4)(d) or (6)(b) orders, a CHILD placed in a SUBSCRIBER home for adoption;

3. A sending agency, as defined in Wis. Stat. § 48.988 (2)(d), places a CHILD in a SUBSCRIBER'S home under § 48.988 for adoption, or a public child placing agency, as defined in § 48.99 (2)(r), or a private child placing agency, as defined in § 48.99 (2)(p), of a sending state, as defined in § 48.99 (2)(w), places a child in the SUBSCRIBER'S home under § 48.99 as a preliminary step to a possible adoption, and the SUBSCRIBER takes physical custody of the CHILD at any location within the United States;

4. The person bringing the CHILD into this state has complied with Wis. Stat. § 48.98, and the SUBSCRIBER takes physical custody of the CHILD at any location within the United States; or

5. A court of a foreign jurisdiction appoints a SUBSCRIBER as guardian of a CHILD who is a citizen of that jurisdiction, and the CHILD arrives in the SUBSCRIBER'S home for the purpose of adoption by the SUBSCRIBER under Wis. Stat. § 48.839.

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

PREFERRED PHYSICIAN / HOSPITAL / PROVIDER means a PHYSICIAN, HOSPITAL, or other HEALTH CARE PROVIDER that has entered into a written agreement with the HEALTH CARE PROVIDER network shown on a PARTICIPANT'S PLAN Identification Card as of the date upon which the SERVICES are provided. The Preferred Provider Directory is available online at www.wpsic.com/state or by request from WPS. A HEALTH CARE PROVIDER'S preferred status may change from time to time so a PARTICIPANT should check it frequently. A PARTICIPANT may be required to pay a larger portion of the cost of a covered HEALTH CARE SERVICE if he/she sees a NON-PREFERRED PROVIDER. However, HEALTH CARE PROVIDERS who leave the network but appear in the Preferred Provider Directory remain available for the entire CALENDAR YEAR except in cases of normal attrition (that is death, retirement or relocation).

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

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

PREVENTIVE CARE SERVICES means HEALTH CARE SERVICES that are designed to: (1) evaluate or assess health and well-being, (2) screen for possible detection of unrevealed illness, (3) improve health, or (4) extend life expectancy, and that are not for the diagnosis or TREATMENT of an ILLNESS or INJURY.

PRIMARY CARE PHYSICIAN means a PHYSICIAN who directly provides or coordinates a range of health care services for a patient. A PRIMARY CARE PHYSICIAN'S primary practice is Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology and Pediatrics. A physician assistant, nurse practitioner, or certified nurse midwife may also act as a PRIMARY CARE PHYSICIAN.

PSYCHOLOGIST means a person who: (1) has received a doctoral degree in psychology from an accredited college or university; (2) is licensed by the state in which he/she is located; and (3) provides health care services while he/she is acting within the lawful scope of his/her license. A doctoral degree in psychology means a Doctor of Philosophy (Ph. D) or Doctor of Psychology (Psy. D) degree that involves the application of principles of the practice of psychology that is recognized by the American Psychological Association.

RECONSTRUCTIVE SURGERY means surgery performed on abnormal structures of the body caused by: (1) congenital defects; (2) development abnormalities; (3) trauma; (4) infection; (5) tumors; or (6) disease. The presence of a psychological condition alone will not entitle a PARTICIPATING to coverage for reconstructive surgery.

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

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

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

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

SKILLED NURSING CARE means HEALTH CARE SERVICES that: (1) are furnished pursuant to a PHYSICIAN'S orders; (2) requires the skills of professional personnel such as a registered or licensed practical nurse; and (3) is provided either directly by or under the direct supervision of such professional personnel.

SKILLED NURSING FACILITY means an institution or a designated part of one, including but not limited to a sub-acute or rehabilitation facility that:

1. Is operating pursuant to state and federal law;

2. Is under the full-time supervision of a PHYSICIAN or registered nurse;

3. Provides services seven days a week, 24 hours a day, including SKILLED NURSING CARE and therapies for the recovery of health or physical strength;

4. Is not a place primarily for custodial or maintenance care;

5. Requires compensation from its patients;

6. Admits patients only upon a PHYSICIAN'S orders;

7. Has an agreement to have a PHYSICIAN'S SERVICES available when needed;

8. Maintains adequate records for all patients; and

9. Has a written transfer agreement with at least one HOSPITAL.

SMP means State Maintenance Plan.

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

SPECIALTY PHYSICIAN means any PHYSICIAN whose primary practice is not one of the following: Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology and Pediatrics.

STANDARD PLAN means this CONTRACT excluding Wisconsin Public Employers and Medicare Plus coverage.

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

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

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

SURGICAL SERVICES means (1) an operative procedure performed by a PHYSICIAN that we recognize as TREATMENT of an ILLNESS or INJURY; or (2) those SERVICES WPS identifies as SURGICAL SERVICES, including sterilization procedures and PREOPERATIVE CARE and POSTOPERATIVE CARE. SURGICAL SERVICES do not include: (1) the reversal of a sterilization procedure; (2) ORAL SURGERY SERVICES; and (3) MATERNITY SERVICES.

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

TREATMENT means management and care directly provided to a PARTICIPANT by a PHYSICIAN or other HEALTH CARE PROVIDER for purposes of diagnosing, healing, curing, and/or combating an ILLNESS or INJURY, as determined by WPS.

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

SCHEDULE OF BENEFITS

Annual Deductible Amount and Copayments

The DEDUCTIBLE applies to all BENEFITS, unless the CONTRACT states otherwise.

1. Annual Deductible Amount for HEALTH CARE SERVICES Provided by a PREFERRED PROVIDER.

The annual DEDUCTIBLE amount is $500 per PARTICIPANT, not to exceed $1,000 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated below will NOT be used to satisfy this annual DEDUCTIBLE amount.

2. Annual DEDUCTIBLE Amount for HEALTH CARE SERVICES Provided by a NON-PREFERRED PROVIDER.

The annual DEDUCTIBLE amount is $1,000 per PARTICIPANT, not to exceed $2,000 per family. The annual DEDUCTIBLE amount applies each CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a NON-PREFERRED PROVIDER must add up to the appropriate DEDUCTIBLE amount before benefits are payable for other CHARGES for covered expenses. No benefits are payable for the CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE amount. CHARGES for covered expenses for HEALTH CARE SERVICES applied by WPS to satisfy the annual DEDUCTIBLE amount stated above will NOT be used to satisfy this annual DEDUCTIBLE amount.

3. Emergency Room COPAYMENT.

The COPAYMENT amount for a PARTICIPANT'S use of a hospital emergency room is $75. The copayment amount applies to each PARTICIPANT for each visit to the hospital emergency room. For each PARTICIPANT, CHARGES for covered expenses must add up to the COPAYMENT amount before BENEFITS are payable for CHARGES for the emergency room fee billed by the HOSPITAL for use of the hospital emergency room (not including PHYSICIAN CHARGES or MISCELLANEOUS HOSPITAL EXPENSES). No BENEFITS are payable for the CHARGES used to satisfy a PARTICIPANT'S COPAYMENT. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate COPAYMENT. The hospital emergency room COPAYMENT will be waived for that visit if the PARTICIPANT is admitted as a resident patient to the HOSPITAL directly from the HOSPITAL emergency room or for observation for 24 hours or longer. This COPAYMENT is in addition to the annual DEDUCTIBLE amount stated above. This COPAYMENT continues to apply after the annual deductible and coinsurance out of pocket limit is met until the maximum out-of-pocket limit for preferred providers is met.

Coinsurance

1. COINSURANCE for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER.

After the annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER at 80%, unless specifically stated otherwise in the PLAN.

2. COINSURANCE for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a NON-PREFERREDPROVIDER.

After the DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable for CHARGES for the covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a NON-PREFERRED PROVIDER at 70%, unless specifically stated otherwise in the PLAN, up to the annual out-of-pocket limit stated below.

3. COINSURANCE for Independent Anesthesiologists.

After the PREFERRED PROVIDER annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 80% of the CHARGES for HEALTH CARE SERVICES provided and billed by an independent anesthesiologist, unless specifically stated otherwise in the PLAN.

4. COINSURANCE for Radiology, Pathology and Laboratory Services.

After the PREFERRED PROVIDER annual DEDUCTIBLE amount stated above is satisfied, BENEFITS are payable at 80% of the CHARGES for radiology, pathology and laboratory services for TREATMENT of an ILLNESS or INJURY. This includes x-rays, laboratory services, allergy testing, MRI's, CT scans, pap smears and mammograms.

5. COINSURANCE for HOSPITAL Emergency Room Visits.

After the emergency room COPAYMENT and PREFERRED PROVIDER annual DEDUCTIBLE amount stated above are satisfied, BENEFITS are payable at 80% of the CHARGES for the emergency room fee billed by the HOSPITAL for use of the HOSPITAL emergency room, PHYSICIAN'S PROFESSIONAL SERVICES and MISCELLANEOUS HOSPITAL EXPENSES for HEALTH CARE SERVICES provided during the visit to the HOSPITAL emergency room.

6. COINSURANCE for Routine Physical Examinations and Other PREVENTIVE CARE SERVICES when Required by Federal Law and Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER.

For SERVICES required by federal law, BENEFITS are payable at 100% of charges for routine physical examinations and other preventive services when provided by a PREFERRED PROVIDER, without application of the DEDUCTIBLE amount.

Annual Out-of-Pocket Limit

1. Annual Out-of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER.

The annual deductible and coinsurance out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER is $2,000.00 per PARTICIPANT, not to exceed $4,000.00 per family. This total is made up of the annual DEDUCTIBLE and COINSURANCE amounts for which a PARTICIPANT pays for covered

expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a NON-PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph b. below will NOT be used to satisfy this annual out-of-pocket limit.

2. Annual Out-Of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a NON-PREFERRED PROVIDER.

The annual deductible and coinsurance out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a NON-PREFERRED PROVIDER is $4,000 per PARTICIPANT, not to exceed $8,000 per family. This total is made up of the annual DEDUCTIBLE and COINSURANCE amounts for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a NON-PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph a. above will NOT be used to satisfy this annual out-of-pocket limit.

3. Maximum Annual Out-Of-Pocket Limit for HEALTH CARE SERVICES Directly Provided to a PARTICIPANT by a PREFERRED PROVIDER.

The maximum annual out-of-pocket limit for covered expenses for HEALTH CARE SERVICES directly provided to a PARTICIPANT by a PREFERRED PROVIDER is $6,850 per PARTICIPANT, not to exceed $13,700 per family. This total is made up of the annual DEDUCTIBLE and COINSURANCE amounts, emergency room COPAYMENTS and applicable prescription drug COPAYMENTS for which a PARTICIPANT pays for covered expenses for HEALTH CARE SERVICES directly provided to the PARTICIPANT by a PREFERRED PROVIDER in one CALENDAR YEAR. CHARGES for covered expenses for HEALTH CARE SERVICES provided by a PREFERRED PROVIDER and applied by WPS to satisfy the annual out-of-pocket limit stated in paragraph a. above will NOT be used to satisfy this annual out-of-pocket limit.

No BENEFITS are payable for CHARGES used to satisfy the annual out-of-pocket limit, including a participant's annual DEDUCTIBLE and COINSURANCE amounts. The PARTICIPANT is responsible for paying the CHARGES used to satisfy the appropriate DEDUCTIBLE and COINSURANCE amounts.

After the applicable annual deductible and coinsurance out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in the PLAN, incurred by the PARTICIPANT during the remainder of the CALENDAR YEAR, subject to any applicable COPAYMENT amounts and all other terms, conditions and provisions of the PLAN.

After the maximum annual out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES without further application of any applicable COPAYMENT amounts.

BENEFIT PROVISIONS

Payment of BENEFITS

Any payment of BENEFITS is subject to: (1) the applicable deductible amount; (2) coinsurance; (3) the applicable copayment amount; (4) a PARTICIPANT'S out-of-pocket limit; (5) exclusions; and all other limitations shown in the PLAN.

1. DEDUCTIBLE Amounts.

Each year, a PARTICIPANT is required to pay a certain amount of charges out-of-pocket before most BENEFITS are payable under the PLAN. These out-of-pocket amounts are called DEDUCTIBLES.

Your DEDUCTIBLE amounts are shown in the Schedule of Benefits section. No BENEFITS are payable under the PLAN for CHARGES used to satisfy a PARTICIPANT'S DEDUCTIBLE amount.

After a PARTICIPANT reaches his/her applicable DEDUCTIBLE amount, most CHARGES for covered expenses will still be subject to any COPAYMENT and/or COINSURANCE amounts shown in the Schedule of Benefits.

2. COINSURANCE.

COINSURANCE is the PLAN'S share of the CHARGE calculated as a percent of the covered expense. For example, if the PLAN's share as shown in the Schedule of Benefits is 80%, then a PARTICIPANT would be responsible for the remaining 20% of the CHARGE, in addition to any amounts in excess of the amount WPS determines to be the CHARGE. After a PARTICIPANT satisfies his/her applicable DEDUCTIBLE or COPAYMENT amount, the PARTICIPANT will only be responsible for HIS/HER portion of the COINSURANCE. The COINSURANCE, if any, applies unless the PARTICIPANT has reached his/her out-of-pocket limit.

3. COPAYMENTS.

A copayment is the fixed amount a PARTICIPANT pays for a covered HEALTH CARE SERVICE, usually when he/she receives the SERVICE. As set forth below and in the Schedule of Benefits, the COPAYMENT amount will vary by the type of SERVICE. The PARTICIPANT may also have a COPAYMENT when he/she gets a prescription filled.

4. OUT-OF-POCKET LIMITS.

The OUT-OF-POCKET LIMIT is the maximum out-of-pocket amount that a PARTICIPANT is required to pay each CALENDAR YEAR for covered HEALTH CARE SERVICES. This limit is shown in the Schedule of Benefits.

Any of the following costs will count towards a PARTICIPANT'S OUT-OF-POCKET LIMIT: (a) the DEDUCTIBLE; (b) COPAYMENTS; and (c) COINSURANCE amounts a PARTICIPANT pays for covered expenses associated with HEALTH CARE SERVICES.

In determining whether a PARTICIPANT has reached his/her OUT-OF-POCKET LIMIT, the following amounts will not count:

a. amounts you pay for non-covered HEALTH CARE SERVICES; and

b. amounts the PARTICIPANT pays that exceed WPS' determination of the CHARGE.

After the PARTICIPANT'S OUT-OF-POCKET LIMIT is reached, BENEFITS are payable at 100% of the CHARGES for covered HEALTH CARE SERIVICES he/she receives during the remainder of the CALENDAR YEAR, subject to all other terms, conditions and provisions of the PLAN.

COVERED EXPENSES

HEALTH CARE SERVICES described in this subsection are covered expenses as long as they are:

1. MEDICALLY NECESSARY;

2. Ordered by a PHYSICIAN for a covered ILLNESS, covered INJURY, or for preventive care;

3. Provided by any HEALTH CARE PROVIDER licensed to provide a HEALTH CARE SERVICE covered under the PLAN.

If the HEALTH CARE SERVICE is not listed in this subsection, that HEALTH CARE SERVICED is not covered and no BENEFITS are payable under the PLAN.

BENEFITS for CHARGES for covered CONFINEMENTS are subject to: (1) preadmission and continued stay certification requirements; and (2) the reductions in benefits shown in Section "WPS MEDICAL MANAGEMENT PROGRAM" for failure to comply with the certification requirements. Please see section "WPS MEDICAL MANAGEMENT PROGRAM."

BENEFITS are not payable for MAINTENANCE CARE, CUSTODIAL CARE, SUPPORTIVE CARE, or any HEALTH CARE SERIVCE to which an exclusion applies. Please see section "EXCLUSIONS AND LIMITATIONS" For detailed information about the PLAN'S exclusions.

All benefits are subject to the DEDUCTIBLE and COINSURANCE amounts, COPAYMENT amounts, OUT-OF-POCKET LIMITS and all other provisions stated in the Schedule of Benefits.

1. Alcoholism TREATMENT.

See paragraph 6. for BENEFITS for alcoholism TREATMENT.

2. Allergy Testing and TREATMENT.

Therapy and testing for TREATMENT of allergies.

3. Ambulance SERVICES.

BENEFITS are payable for CHARGES for professional licensed ambulance SERVICE when necessary to transport a PARTICIPANT to or from a HOSPITAL subject to the PREFERRED PROVIDER DEDUCTIBLE and COINSURANCE. SERVICES include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance SERVICE is unavailable and such transportation is substantiated by a PHYSICIAN as being MEDICALLY NECESSARY.

4. Anesthesia SERVICES.

Anesthesia SERVICES in connection with SERVICES that are a BENEFIT under the PLAN.

5. Autism SERVICES.

TREATMENT of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or

pervasive developmental disorder not otherwise specified. TREATMENT of autism spectrum disorders is covered when the TREATMENT is prescribed by a PHYSICIAN and provided by any of the following HEALTH CARE PROVIDERS: psychiatrist, PSYCHOLOGIST, social worker, paraprofessional working under the supervision of any of those three types of providers, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Benefits payable up to $57,678 per year for intensive-level and up to $28,839 per calendar year for nonintensive-level services are not subject to contract exclusions and limitations that apply to any other ILLNESS. These minimum coverage monetary amounts shall be adjusted annually as determined by the Office of the Commissioner of Insurance. The therapy limit does not apply to this benefit.

6. Behavioral Health SERVICES.

a. Definitions. The following definitions apply to this paragraph only:

COLLATERAL: a member of a PARTICPANT'S immediate family.

DAY TREATMENT PROGRAMS: nonresidential programs for alcohol and drug-dependent PARTICIPANTS and for TREATMENT of NERVOUS OR MENTAL DISORDERS that are operated by certified inpatient and outpatient Alcohol and Other Drug Abuse (AODA) facilities that provide case management, counseling, medical care and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week; also known as partial hospitalization.

HOSPITAL: (1) a hospital licensed under Wis. Stat. §50.35; (2) an approved private treatment facility as defined in Wis. Stat. §51.45 (2) (b); or (3) an approved public treatment facility as defined in Wis. Stat. §51.45 (2) (c).

INPATIENT HOSPITAL SERVICES: SERVICES for the TREATMENT of NERVOUS OR MENTAL DISORDERS, alcoholism or drug abuse that are directly provided to a PARTICIPANT who is a bed patient in the hospital. However this definition shall not include those inpatient hospital services for detoxification of drug addiction or alcohol dependency. Please see paragraph "Hospital Services."

LICENSED MENTAL HEALTH PROFESSIONAL: a clinical social worker licensed under Wis. Stat. §457.08, a marriage and family therapist licensed under §457.10, or a professional counselor licensed under §457.12.

OUTPATIENT SERVICES: nonresidential SERVICES for the TREATMENT of NERVOUS OR MENTAL DISORDERS, alcoholism or drug abuse problems directly provided to a PARTICIPANT and, if for the purpose of enhancing his/her TREATMENT, a COLLATERAL by any of the following: (1) a program in an outpatient treatment facility, if both the program and facility are approved by the Department of Health Services and established and maintained according to rules promulgated under Wis. Stat. s. 51.42 (7)(b); (2) a licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the PHYSICIAN'S office; (3) a PSYCHOLOGIST licensed or certified by the state in which he/she is located; (4) a LICENSED MENTAL HEALTH PROFESSIONAL practicing within the scope of his/her license under Wis. Stat. Chapter 457 and applicable rules; or (5) a HEALTH CARE PROIVDER licensed to provide nonresidential SERVICES for the TREATMENT of NERVOUS OR MENTAL DISORDERS, alcoholism or drug abuse within the scope of that license.

RESIDENTIAL TREATMENT PROGRAMS: therapeutic programs for TREATMENT of NERVOUS OR MENTAL DISORDERS and alcohol and drug dependent PARTICIPANTS, including therapeutic communities and transitional facilities.

TRANSITIONAL TREATMENT: SERVICES for the TREATMENT of NERVOUS OR MENTAL DISORDERS, alcoholism or drug abuse that are directly provided to a PARTICIPANT in a less restrictive manner than INPATIENT HOSPITAL SERVICES but in a more intensive manner than OUTPATIENT SERVICES, if both the program and the facility are approved by the Department of Health Services as defined in the Wis. Admin. Code INS 3.37.

TRANSITIONAL TREATMENETS are SERVICES provided by a HEALTH CARE PROVIDER and certified by the Department of Health Services for each of the following (except (8)) below:

(1) mental health services for covered adults in a day treatment program;

(2) mental health services for covered children and adolescents in a day treatment program;

(3) services for covered persons with chronic mental illness provided through a community support program;

(4) RESIDENTIAL TERATMENT PROAMS for TREATMENT of a PARTICIPANT'S NERVOUS OR MENTAL DISORDERS and for alcohol or drug dependent PARTICIPANTS or both;

(5) SERVICES for alcoholism and other drug problems provided in a DAY TREATMENT PROGRAM;

(6) intensive outpatient programs for narcotic treatment services for opiate addiction and for TREATMENT of NERVOUS OR MENTAL DISORDERS;

(7) coordinated emergency mental health SERVICES which are provided by a LICENSED MENTAL HEALTH PROFESSIONAL for PARTICIPANTS who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided; and

(8) out-of-state SERVICES and programs that are substantially similar to 1. through 7. above if the provider is in compliance with similar requirements of the state in which the HEALTH CARE PROIVDER is located.

The criteria that WPS uses to determine if a TRANSITIONAL TREATMENT is MEDICALLY NECESSARY and covered under the PLAN include, but are not limited to, whether:

(1) the TRANSITIONAL TREATMENT is certified by the Department of Health Services;

(2) the TRANSITIONAL TREATMENT meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;

(3) the specific diagnosis is consistent with the symptoms;

(4) the TRANSITIONAL TREATMENT is standard medical practice an***d appropriate for the specific diagnosis;

(5) the TRANSITIONAL TREATMENT plan is focused for the specific diagnosis; and

(6) the multidisciplinary team running the TRANSITIONAL TREATMENT is under the supervision of a licensed psychiatrist practicing in the same state in which the HEALTH CARE PROVIDER's program is located or the SERVICE is provided;

WPS will need the following information from the HEALTH CARE PROVIDER to help it determine the medical necessity of a TRANSITIONAL TREATMENT:

(1) a summary of the development of a PARTICIPANT'S ILLNESS and previous TREATMENT;

(2) a well-defined treatment plan listing TREATMENT objections, goals and duration of the care provided under the TRANSITIONAL TREATMENT program; and

(3) a list of credentials for the staff who participated in the TRANSITIONAL TREATMENT program or service, unless the program or SERVICE is certified by the Department of Health Services.

b. **BENEFITS.** The PLAN will pay BENEFITS for CHARGES for covered expenses a PARTICIPANT incurs for INPATIENT HOSPITAL SERIVCES, OUTPATIENT SERVICES and TRANSITIONAL TREATMENT that he/she receives each CALENDAR YEAR.

No BENEFITS are payable for CHARGES for OUTPATIENT SERVICES provided to or received by a PARTICIPANT as a COLLATERAL of a patient when those OUTPATIENT SERVICES do not enhance the outpatient treatment of another PARICIPANT who is also covered under the PLAN.

7. Blood and Blood Plasma.

Whole blood; blood plasma; and blood products, including platelets.

8. Cardiac Rehabilitation SERVICES.

Cardiac rehabilitation SERVICES limited to the following:

a. Phase I, while a PARTICIPANT is confined as an INPATIENT in a HOSPITAL;

b. Phase II, while a PARTICIPANT is an OUTPATIENT receiving SERVICES in a facility with a facility-approved cardiac rehabilitation program.

BENEFITS are payable for CHARGES for up to 78 supervised and monitored exercise sessions per covered ILLNESS starting with the first session in the OUTPATIENT exercise program. BENEFITS are not payable for behavioral or vocational counseling. No other BENEFITS for OUTPATIENT cardiac rehabilitation SERVICES are available under the PLAN.

9. Chiropractic SERVICES.

Spinal manipulations and diagnostic tests provided by a chiropractor.

For therapy benefits, please see subsection "Therapy SERVICES."

10. Clinical Trials.

BENEFITS are payable as stated in the PLAN for a PARTICIPANT'S participation in an approved clinical trial with respect to the TREATMENT of cancer or another life threatening disease or condition.

11. Contraceptives for Birth Control.

Devices or medications used as contraceptives that require a prescription or intervention by a physician or other licensed HEALTH CARE PROVIDER, including related HEALTH CARE SERVICES. Examples include:

a. intrauterine devices (IUD);

b. subdermal contraceptive implants;

c. injections of medication for birth control; and

d. contraceptive devices obtained directly from a PHYSICIAN.

Coverage of additional contraceptives, including, but not limited to, oral contraceptives, contraceptive patches, diaphragms, and contraceptive vaginal rings purchased at a pharmacy are covered under the prescription legend drug benefits of the Pharmacy Benefit Manager.

12. Dental SERVICES.

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

BENEFITS are also payable for:

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

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

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

13. Diabetes TREATMENT.

BENEFITS are payable for CHARGES incurred for the installation and use of an insulin infusion pump and all other equipment and supplies, excluding insulin, used in the TREATMENT of diabetes. Coverage for insulin are payable when purchased at a pharmacy and are covered under the prescription legend drug benefits of the Pharmacy Benefit Manager.

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

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

b. charges for the disposable supplies listed above when dispensed by a health care provider other than a pharmacy are payable as stated in this paragraph 13.

This benefit is limited to the purchase of one insulin infusion pump per PARTICIPANT per CALENDAR YEAR, provided the replacement is MEDICALLY NECESSARY as determined by WPS. BENEFITS are also payable for CHARGES for diabetic self-management education programs, but only if WPS determines that the program is MEDICALLY NECESSARY.

14. Diagnostic SERVICES.

Diagnostic radiology and laboratory SERVICES directly provided to a PARTICIPANT for radiology and lab tests related to a covered PHYSICAL ILLNESS or INJURY. If the laboratory tests are performed by a PREFERRED PROVIDER, but are sent to a NON-PREFERRED PROVIDER or non-preferred facility for analysis, the laboratory SERVICES will be paid at the PREFERRED PROVIDER rate. WPS' prior approval is required for outpatient high-technology radiology tests (MRI, MRA, CT or CTA Scan, PET scans and nuclear stress tests), including related SERVICES, except those provided as EMERGENCY MEDICAL CARE. If a PARTICIPANT does not receive WPS' prior approval, benefits are not payable under the PLAN. However, if a claim is denied solely because the PARTICIPANT did not receive WPS' prior approval, WPS may review the SERVICES for payment under the PLAN based on medical necessity provided the PARTICIPANT requests WPS to review the claim and provides additional documentation from his/her PHYSICIAN as to the medical necessity of the high-technology radiology test.

15. Drug Abuse TREATMENT.

See subsection "Behavioral Health Services" for BENEFITS for drug abuse TREATMENT.

16. DURABLE MEDICAL EQUIPMENT.

Rental of or, at the option of WPS, purchase of DURABLE MEDICAL EQUIPMENT. When the equipment is purchased, BENEFITS are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. If the DURABLE MEDICAL EQUIPMENT is purchased, BENEFITS are payable for CHARGES up to the purchase price of that DURABLE MEDICAL EQUIPMENT. Rental fees exceeding the purchase price, routine periodic maintenance and replacement of batteries are not covered.

17. EMERGENCY MEDICAL CARE.

BENEFITS are payable for HEALTH CARE SERVICES provided in a HOSPITAL emergency room as shown in the Schedule of Benefits. If a COPAYMENT is shown, this copayment applies to the emergency room fee billed by the HOSPITAL for use of the HOSPITAL emergency room. If you received health care services for an urgent care facility within a HOSPITAL, this emergency room COPAYMENT shall apply. The PLAN will waive the EMERGENCY ROOM COPAYMENT if a PARTICIPANT is admitted as a resident patient to the HOSPITAL directly from the HOSPITAL emergency room.

If a PARTICIPANT is admitted as a resident patient to the HOSPITAL directly from the HOSPITAL emergency room, CHARGES for covered expenses provided in the HOSPITAL emergency room shall be payable subject to the applicable DEDUCTIBLE and COINSURANE that applies to that HOSPITAL CONFINEMENT.

18. Genetic SERVICES.

BENEFITS are payable for charges for the following genetic SERVICES:

a. genetic counseling provided to a PARTICIPANT by a PHYSICIAN, licensed or Master's trained genetic counselor or medical geneticist. Genetic counseling, includes evaluation for BRCA testing for a female PARTICIPANT whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations;

b. amniocentesis during pregnancy;

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

d. identification of infectious agents such as the influenza virus and hepatitis. Panel testing for multiple agents is not covered unless a PARTICPANT'S PHYSICIAN provides a justification for including each test in the panel;;

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

f. cystic fibrosis testing as recommended by the American College of Medical Genetics;

g. molecular testing of pathological specimens. Such testing does not include testing of blood except for testing for the diagnosis of leukemia, lymphoma, or platelet abnormalities. Molecular testing as part of a genetic panel analysis requires WPS' prior authorization;

h. BRCA testing for a female PARTICIPANT whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations.

i. All other GENETIC TESTING, provided a PARTICIPANT receives our prior authorization. If a PARTICIPANT does not receive WPS' prior approval, BENEFITS for such SERVICES may not be payable under the PLAN. WPS will authorize GENETIC TESTING if his/her PHYSICIAN shows that the results of such testing will directly impact his/her future treatment. The PARTICIPANT'S PHYSICIAN must describe how and why, based on the GENETIC TESTING results, his/her individual TREATMENT plan would be different than his/her current or expected TREATMENT plan based on a clinical assessment without GENETIC TESTING. Upon request, a PARTICIPANT'S PHYSICIAN must submit information regarding the GENETIC TESTING'S clinical validity and clinical utility. GENETIC TESTING that WPS considers EXPERIMENTAL or INVESTIGATIONAL will not be covered.

19. Health and Behavior Assessments and Neuropsychological Testing.

BENEFITS are payable for health and behavior assessments and reassessments, diagnostic interviews and neuropsychological testing provided by a PSYCHOLOGIST to treat a PHYSICAL ILLNESS or INJURY.

20. HEARING AIDS and COCHLEAR IMPLANTS.

As required by Wis. Stat. §632.895 (16), BENEFITS are payable for CHARGES for: (a) the cost of one HEARING AID, per ear, per child every three years; (b) COCHLEAR IMPLANTS; and (c) treatment related to HEARING AIDS and COCHLEAR IMPLANTS, including procedures for the implantation of COCHLEAR IMPLANTS. This paragraph applies only to children under the age of 18 who are covered under the PLAN. Such HEARING AIDS and COCHLEAR IMPLANTS must be prescribed by a PHYSICIAN or an audiologist in accordance with accepted professional medical or

audiological standards. The child must be certified as deaf or hearing impaired by a PHYSICIAN or audiologist.

21. HOME CARE SERVICES.

a. BENEFITS. This paragraph applies only if CHARGES for HOME CARE SERVICES are not covered elsewhere under the CONTRACT. BENEFITS are payable for CHARGES for the following HOME CARE SERVICES, subject to paragraph b. below:

(1) part time or intermittent home nursing care by or under supervision of a registered nurse;

(2) part time or intermittent home health aide SERVICES that: (a) are part of the HOME CARE plan; (b) consist solely of care for the patient; and (c) are supervised by a registered nurse or medical social worker;

(3) physical or occupational therapy or speech-language pathology or respiratory care;

(4) MEDICAL SUPPLIES, prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN required to be administered by a professional provider; laboratory SERVICES by or on behalf of a HOSPITAL, if needed under the HOME CARE plan. These items are covered to the extent they would be if the PARTICIPANT had been hospitalized;

(5) nutrition counseling provided or supervised by a registered dietician or certified dietician; and

(6) evaluation of the need for a HOME CARE plan by a registered nurse, physician extender or medical social worker. The PARTICIPANT'S attending PHYSICIAN must request or approve this evaluation.

b. Limitations. Home care is covered if ordered by a PHYSICIAN and determined by WPS to be MEDICALLY NECESSARY. The PLAN covers home safety evaluations, evaluations for a home TREATMENT program, and/or initial visit(s) to evaluate a PARTICIPANT for an independent TREATMENT plan. For all other HOME CARE to be determined MEDICALLY NECESSARY, the PARTICIPANT must be confined to his/her home due to an ILLNESS, INJURY or because leaving his/her home would be contraindicated. Examples of HOME CARE include, but are not limited to, IV administration, or wound care.

Benefits are limited to 50 HOME CARE visits per PARTICIPANT per CALENDAR YEAR. 50 additional visits per PARTICIPANT per CALENDAR YEAR may be available if MEDICALLY NECESSARY and approved by WPS. Each visit by a person to provide SERVICES under a HOME CARE plan, or for evaluating his/her need, or for developing a HOME CARE plan counts as one HOME CARE visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one HOME CARE visit.

The maximum weekly BENEFIT for this coverage won't be more than the weekly CHARGES for SKILLED NURSING CARE in a LICENSED SKILLED NURSING FACILITY, as determined by WPS.

If HOME CARE is covered under two or more health insurance contracts, coverage is payable under only one of them. The same is true if the PARTICIPANT has HOME CARE coverage under this CONTRACTR and another source.

22. Home Intravenous (IV) Therapy or Infusion Therapy.

Intravenous (IV) therapy/infusion therapy performed in your home if prescribed by a physician. Home IV therapy or home infusion therapy includes, but is not limited to: (a) injections (intra-muscular, subcutaneous, continuous subcutaneous); (b) Total Parenteral Nutrition (TPN); and (c) antibiotic therapy.

23. HOSPICE CARE SERVICES.

a. Benefits. BENEFITS are payable for CHARGES for the following HOSPICE CARE SERVICES:

(1) part-time or intermittent home nursing care by or under the supervision of a registered nurse;

(2) part-time or intermittent home health SERVICES when MEDICALLY NECESSARY. Such SERVICES must be under the supervision of a registered nurse or medical social worker and consist solely of care for the PARTICIPANT;

(3) physical, respiratory, occupational or speech therapy;

(4) MEDICAL SUPPLIES, prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN required to be administered by a professional provider; laboratory SERVICES by or on behalf of a HOSPITAL, to the extent CHARGES would be payable for these items under this CONTRACT if the PARTICIPANT had been hospitalized;

(a) nutrition counseling provided or supervised by a registered nurse, PHYSICIAN extender or medical social worker, when approved or requested by the attending PHYSICIAN; and

(b) room and board CHARGES at a WPS approved or MEDICARE certified HOSPICE CARE facility.

CHARGES for weekly HOSPICE CARE SERVICES are payable up to the weekly CHARGES for SKILLED NURSING CARE provided in a LICENSED SKILLED NURSING FACILITY, as determined by WPS.

b. Limitations. BENEFITS for HOSPICE CARE SERVICES are limited as follows:

(1) HOSPICE CARE is not covered unless the PARTICIPANT'S attending PHYSICIAN certifies that: (a) hospitalization or CONFINEMENT would otherwise be required; (b) necessary care and TREATMENT are not available from members of the PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT; and (c) the PARTICIPANT is terminally ill with a life expectancy of six months or less.

(2) CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a MEDICARE certified or WPS approved HOSPICE CARE facility.

CHARGES are payable for HOSPICE CARE SERVICES provided in a PARTICIPANT'S home up to 80 HOSPICE CARE visits within any six month period.

Up to four consecutive hours of HOSPICE CARE SERVICES in a PARTICIPANT'S home is considered as one HOSPICE CARE visit.

When BENEFITS are payable under both this HOSPICE CARE BENEFIT and the HOME CARE BENEFIT, BENEFITS payable under this subsection shall reduce any BENEFITS payable under the HOME CARE subsection.

24. HOSPITAL SERVICES.

HOSPITAL SERVICES as shown below. This subsection does not include SERVICES for: (a) covered transplants; or (b) TREATMENT of alcoholism, drug abuse or NERVOUS OR MENTAL DISORDERS, except for INPATIENT HOSPITAL SERVICES for detoxification of drug addiction or alcohol dependency. Please see subsections "Behavioral Health SERVICES" and "Transplants."

a. INPATIENT HOSPITAL SERVICES. BENEFITS are payable for the following INPATIENT HOSPITAL SERVICES for a PHYSICAL ILLNESS or INJURY:

(1) CHARGES for room and board;

(2) CHARGES for nursing SERVICES;

(3) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES; and

(4) CHARGES for intensive care unit room and board.

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

If a PARTICIPANT is confined in a HOSPITAL other than a PREFERRED HOSPITAL as an INPATIENT due to a medical emergency, we reserve the right to coordinate your transfer to a preferred hospital once you are stable and can be safely moved to that preferred hospital.

b. Outpatient Hospital Services. BENEFITS are payable for MISCELLANEOUS HOSPITAL EXPENSES for a PHYSICAL ILLNESS or INJURY received by a PARTICIPANT while he/she is not CONFINED in a HOSPITAL. These don't include CHARGES for OUTPATIENT physical, speech, occupational or respiratory therapy.

c. Facility Fees. BENEFITS are payable for facility fees charged by the HOSPITAL for office visits and for urgent care visits.

25. Kidney Disease TREATMENT.

Dialysis TREATMENT, including any related MEDICAL SUPPLIES and laboratory SERVICES provided during dialysis and billed by the OUTPATIENT department of a HOSPITAL or by the dialysis center.

Kidney transplantation SERVICES are payable under the organ transplant benefit in subsection "Transplants."

26. Mastectomy TREATMENT.

BENEFITS are payable for CHARGES for breast reconstruction of the affected tissue following a mastectomy. Benefits are also payable for CHARGES for: surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prostheses; and physical complications for all stages of mastectomy, including lymphedemas.

27. Maternity SERVICES.

MATERNITY SERVICES, including: (a) prenatal and postnatal care; (b) laboratory procedures; (c) delivery of the natural newborn child; (d) cesarean sections; and (e) HEALTH CARE SERVICES for miscarriages.

HEALTH CARE SERVICES related to an abortion are covered provided the abortion procedure for the termination of a mother's pregnancy is permitted by, and performed in accordance with, law.

Maternity SERVICES are payable when provided by a: (a) HOSPITAL; (b) PHYSICIAN; (c) CERTIFIED NURSE MIDWIFE in a clinic or HOSPITAL.

With respect to confinements for pregnancy, the policy shall not limit the length of stay to less than: (a) 48 hours for a normal birth; and (b) 96 hours for a cesarean delivery. However, you are free to leave the hospital earlier if the decision to shorten the stay is the mutual decision of the physician and mother.

28. MEDICAL SERVICES.

MEDICAL SERVICES for a PHYSICAL ILLNESS or INJURY, including second opinions. SERVICES must be provided: (a) in a HOSPITAL; (b) in a PHYSICIAN'S office; (c) in an urgent care center; (d) in a surgical care center; (e) in a convenient care clinic; or (f) in a PARTICIPANT'S home. These SERVICES do not include HOME CARE SERVICES covered elsewhere in this CONTRACT.

BENEFITS are also payable for ADVANCE CARE PLANNING after the PARTICIPANT receives a terminal diagnosis, regardless of life expectancy.

29. MEDICAL SUPPLIES.

MEDICAL SUPPLIES prescribed by a PHYSICIAN. MEDICAL SUPPLIES include, but are not limited to:

a. strapping and crutches;

b. therapeutic contact lenses and cataract lenses following cataract surgery;

c. ostomy bags and supplies, except CHARGES such as those made by a pharmacy for purposes of a fitting are not covered;

d. Elastic stockings or supports when prescribed by a PHYSICIAN and required in the TREATMENT of an ILLNESS or INJURY. WPS may establish reasonable limits on the number of pairs allowed per PARTICIPANT per CALENDAR YEAR; and

e. enteral therapy (tube feeding) supplies if prescribed by a PHYSICIAN and determined by WPS as being appropriate for a PARTICIPANT'S medical condition. This does not include enteral formula, food, food supplements or vitamins.

30. Nutritional Counseling.

Nutritional counseling that is: (a) for TREATMENT of an ILLNESS or INJURY; and (b) provided by a PHYSICIAN, dietician or nutritionist licensed in the state where the counseling is provided to a PARTICIPANT. Nutritional counseling billed as educational SERVICES will not be covered.

31. Orthotic Devices and Appliances.

Externally applied devices or appliances, including fittings and adjustments of custom-made rigid or semi-rigid supportive devices, that: (a) are used to support, align, prevent, or correct

deformities; (b) improve the function of movable parts of the body; or (c) limit or stop motion of a weak or diseased body part. Covered orthotic devices and appliances include, but are not limited to:

a. casts and splints;

b. orthopedic braces, including necessary adjustments to shoes to accommodate braces. Braces that straighten or change the shape of a body part are excluded from coverage;

c. Cervical collars;

d. Orthoses; and

e. Corsets (back and special surgical).

However, orthotic devices or appliances to support the foot are not covered unless they are a permanent part of an orthopedic leg brace.

Orthotic devices or appliances may be replaced once per CALENDAR YEAR per PARTICIPANT when medically necessary. Additional replacements will be allowed: (a) if the PARTICIPANT is under age 18 due to rapid growth; or (b) when a device or appliance is damaged and cannot be repaired.

The PLAN does not cover routine periodic maintenance, such as testing, cleaning and checking of the device or appliance.

32. Pain Management TREATMENT.

BENEFITS are payable for pain management TREATMENT including injections and other procedures to manage a PARTICIPANT'S pain related to an ILLNESS or INJURY.

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

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

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

c. facet joint injections and medical branch nerve blocks;

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

e. sacroiliac joint injections;

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

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

33. Prescription Drugs Dispensed by Other Than a Pharmacy.

BENEFITS are payable for CHARGES for prescription drugs, including self-administered injectable medication, and injectable and infusible medication when required to be used in a PHYSICIAN'S office, a HOSPITAL, or by a home health agency during HOME CARE.

34. PREVENTIVE CARE SERVICES.

PREVENTIVE CARE SERVICES ordered by a PHYSICIAN. Covered PREVENTIVE CARE SERVICES include:

a. Immunizations including, but not limited to, those recommended by the Advisory Committee on Immunization Practices: influenza/flu, diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; haemophilus influenza B; meningitis; hepatitis A; hepatitis B; varicella; pneumococcal; meningococcal; rotavirus; human papillomavirus; and herpes zoster. Immunizations for travel purposes are not covered. The annual DEDUCTIBLE and COINSURANCE amounts do not apply to immunizations provided to PARTICIPANTS to age six and for those immunizations required by Federal law.

b. PREVENTIVE CARE SERVICES limited to, those recommended by the United States Preventive Services Task Force with an A or B rating:

(1) routine physical examinations, pelvic exams and pap smears, and related diagnostic services performed and billed by a PHYSICIAN, other than routine mammograms and colorectal cancer screening. Pelvic exams and pap smears are covered under this paragraph when directly provided to a PARTICIPANT by a PHYSICIAN, CERTIFIED NURSE MIDWIFE or a NURSE PRACTITIONER. Physical examinations requested by a third party are not covered under this CONTRACT.

(2) one two-dimensional mammogram of a female PARTICIPANT per CALENDAR YEAR. Mammograms must be performed by or under the direction of a PHYSICIAN, CERTIFIED NURSE MIDWIFE or NURSE PRACTITIONER.

(3) blood lead tests.

(4) preventive screenings including, but not limited to:

(a) screening for abdominal aortic aneurysm;

(b) screening and behavioral counseling to reduce alcohol misuse, as determined by WPS;

(c) screening for chlamydial infection;

(d) colorectal cancer screening, including fecal occult blood testing, one routine sigmoidoscopy or colonoscopy, including related HEALTH CARE SERVICES, every five years, in accordance with the most current guidelines of the United States Preventive Services Task Force. Any additional routine sigmoidoscopies or colonoscopies performed within that five year period shall be payable subject to applicable DEDUCTIBLE and COINSURANCE provisions;

(e) screening for gonorrhea;

(f) screening for congenital hypothyroidism in newborns;

(g) screening for hearing loss in newborns;

(h) screening for Hepatitis B and C;

(i) screening for high blood pressure;

(j) screening for HIV;

(k) screening for iron deficiency anemia in asymptomatic pregnant women;

(l) screening for lipid disorders;

(m) screening for major depressive disorders in children and adolescents;

(n) screening for phenylketonuria in newborns;

(o) screening for RH incompatibility;

(p) screening for osteoporosis;

(q) screening for sickle cell disease in newborns;

(r) screening for syphilis;

(s) screening for type 2 diabetes;

(t) screening for visual impairment in children under age five;

(u) screening for depression in adults;

(v) screening for bacteriura;

(w) screening for cervical cancer;

(x) screening and behavioral counseling for obesity, as determined by WPS.

(y) screening for gestational diabetes in pregnant women who are between 24 and 28 weeks of gestation and at the first prenatal visit if the woman is identified to be at high risk for diabetes;

(z) high risk human papillomavirus DNA testing in female covered persons with normal cytology results. Screening should begin at age 30 and should occur no more frequently than every three years;

(aa) screening for lung cancer with low-dose computed tomography in adults aged 55 to 80 who have a 30 pack-year smoking history and currently smoke or have quit smoking within the last 15 years;

(bb) **a**utism screening for children at 18 and 24 months

(cc) behavioral assessments for children at the following ages: 0-11 months, 1-4 years, 5-10 years, 11-14 years and 15-17 years

(dd) developmental screening for children under age 3.

(ee) height, weight and body mass index measurements for children at the following ages: 0-11 months,1-4 years,5-10 years,11-14 years and 15-17 years.

(ff) screening for hematocrit or hemoglobin in children.

(5) behavioral interventions to promote breast feeding; comprehensive lactation support and counseling by a trained health care provider during pregnancy and/or in the postpartum period;

(6) annual counseling on sexually transmitted infections;

(7) counseling for tobacco use;

(8) prophylactic ocular topical medication for newborns against gonococcal opthalmia neonatorum;

(9) annual screening and counseling for female covered persons for interpersonal and domestic violence;

(10) healthy diet and physical activity counseling to prevent cardiovascular disease;

(11) behavioral counseling for skin cancer.

(12) exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at risk for falls.

(13) Diet counseling for adults at higher risk for chronic disease.

Some laboratory and diagnostic studies may be subject to a DEDUCTIBLE and/or COINSURANCE if determined not to be part of a routine preventive or screening examination. When a PARTICIPANT has a symptom or history of an ILLNESS or INJURY, laboratory and diagnostic studies related to that ILLNESS or INJURY are no longer considered part of a routine preventive or screening examination.

35. Prosthetics.

Prosthetic devices and supplies, including the fitting of such devices, that replace all or part of: (a) an absent body part (including contiguous tissue); or (b) the function of a permanently inoperative or malfunctioning body part. Benefits are limited to one purchase no sooner than every three years of each type of the standard model, as determined by WPS. Prosthetic devices include, but are not limited to, artificial limbs, eyes, and larynx. The PLAN will also cover replacement or repairs if WPS determines that they are MEDICALLY NECESSARY. The PLAN does not cover dental prosthetics.

36. Radiation Therapy and Chemotherapy Services.

Radiation therapy and chemotherapy SERVICES. BENEFITS are also payable for for CHARGES for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in conjunction with radiation therapy and chemotherapy SERVICES.

37. Skilled Nursing Care in a Skilled Nursing Facility.

Skilled nursing care a PARTICIPANT receives while confined in a SKILLED NURSING FACILITY if: (a) the PARTICIPANT is admitted to a SKILLED NURSING FACILITY within 24 hours after discharge from a HOSPITAL; and (b) the PARTICIPANT is admitted for continued TREATMENT of the same ILLNESS or INJURY treated in the HOSPITAL.

BENEFITS are payable for such SKILLED NURSING CARE provided to a PARTICIPANT at that facility for up to 120 days of CONFINEMENT per CALENDAR YEAR. The 120-day limit stated in this paragraph will be reduced by any CHARGES for such days of CONFINEMENT that are applied to the applicable DEDUCTIBLE amounts.

38. SURGICAL SERVICES.

SURGICAL SERVICES as stated below. This paragraph does not include SURGICAL SERVICES for: (a) covered transplants; (b) pain management procedures; or (c) behavioral health services. Please see paragraphs "Behavioral Health Services," "Transplants," and "Pain Management Treatment."

Covered SURGICAL SERVICES include, but are not limited to:

a. Operative and cutting procedures;

b. Endoscopic examinations, such as: (1) arthroscopy; (2) bronchoscopy; or (3) laparoscopy; and

c. Other invasive procedures such as: (1) angiogram; (2) ateriogram; or (3) tap or puncture of brain or spine.

The following SURGICAL SERVICES are covered when provided in a PHYSICIAN'S office, HOSPITAL, or licensed surgical center:

a. SURGICAL SERVICES, other than RECONSTRUCTIVE SURGERY and ORAL SURGERY.

b. RECONSTRUCTIVE SURGERY for the TREATMENT of the following:

(1) a congenital ILLNESS or anomaly that results in a functional impairment;

(2) an abnormality resulting from an INJURY; and

(3) an abnormality resulting from infection or other disease of the involved body part, if such surgery occurs within 12 months of being diagnosed of the abnormality.

c. Sterilization procedures. Please note that reversal of a sterilization procedure is not covered under the PLAN.

d. Bariatric surgery for weight reduction, provided a PARTICIPANT meets all criteria established by WPS. PARTICIPANTS should request WPS' preauthorization of such a surgical procedure prior to receiving HEALTH CARE SERVICES.

e. ORAL SURGERY, including related consultation, x-rays and anesthesia, limited to the following procedures:

(1) surgical exposure or removal of impacted teeth;

(2) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(3) surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(4) apicoectomy (excision of the apex of the tooth root);

(5) excision of exostosis (bony outgrowth) of the jaws and hard palate;

(6) frenectomy;

(7) incision and drainage of cellulitis (tissue inflammation) of the mouth;

(8) incision of accessory sinuses, salivary glands or ducts;

(9) gingivectomy (excision of gum tissue to eliminate infection), includes osseous surgery, tissue and bone grafts;

(10) alveolectomy/alveoplasty;

(11) orthognathic surgery and osteotomies;

(12) apical curettage;

(13) gingival curettage under general anesthesia;

(14) removal of residual (retained) root;

(15) TREATMENT of fractured facial bones;

(16) vestibuloplasty;

(17) osteoplasty;

(18) transeptal fiberotomy;

(19) retrograde filling;

(20) hemisection;

(21 coronidectomy; and

(22) surgical removal of erupted teeth.

The extraction of teeth other than by surgery, dental implants, root canal procedures, filling, capping, recapping or other routine repair or maintenance of teeth, alveoplasty with extraction (D7310), and reconstruction of mandible coded 21244, 21245, 21248 and 21249 are excluded.

BENEFITS are not payable for incidental surgical procedures which are performed at the same setting as a major covered surgical procedure, which is the primary procedure. Incidental surgical procedures are one or more surgical procedures performed through the same incision or operative approach as the primary surgical procedure with the highest CHARGE as determined by WPS and which, in WPS' opinion, are not clearly identified and/or do not add significant time or complexity to the surgical session. BENEFITS payable for incidental surgical procedures are limited to the CHARGE for the primary surgical procedure with the highest CHARGE, as determined by WPS. No additional BENEFITS are payable for those incidental surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an incidental surgical procedure (i.e., BENEFITS are payable for the hysterectomy, but not for the removal of the appendix).

39. Temporomandibular Joint Disorders (TMJ).

Diagnostic procedures and surgical or non-surgical TREATMENT for the correction of temporomandibular disorders if all of the following apply:

a. the condition is caused by CONGENITAL, developmental or acquired deformity, disease or INJURY;

b. under the accepted standards of the profession of the HEALTH CARE PROVIDER providing the SERVICE, the procedure is reasonable and appropriate for the diagnosis or TREATMENT of the condition;

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

This includes coverage of non-surgical TREATMENT, including intraoral splint therapy, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Benefits for diagnostic procedures and non-surgical TREATMENT will be payable up to $1,250.00 per CALENDAR YEAR**.**

40. Therapy SERVICES.

Physical, speech, occupational, respiratory and aquatic therapy billed as habilitation or rehabilitation limited to a combined maximum of 50 visits per CALENDAR YEAR. An additional 50 visits may be available if additional visits are MEDICALLY NECESSARY and approved by WPS.

All therapy must be: (a) ordered by a PHYSICIAN prior to commencement of therapy for TREATMENT of an ILLNESS or INJURY; and (b) expected to provide significant measurable gains that will improve a PARTICIPANT'S physical health within 60 days of the date on which such therapy begins. The therapy must be performed by: (a) a PHYSICIAN; (b) a licensed physical, speech, occupational or respiratory therapist or any other HEALTH CARE PROVIDER approved by WPS other than one whom ordinarily resides in the PARTICIPANT'S home or who is a member of the PARTICIPANT'S IMMEDIATE FAMILY; or (c) any other HEALTH CARE PROVIDER approved by WPS. The licensed therapist or other health care provider must be providing the therapy under the direction of your physician.

If a license to perform such therapy is required by law, that therapist or other HEALTH CARE PROVIDER must: (a) be licensed by the state in which he/she is located; and (b) provide such therapy while he/she is acting within the lawful scope of his/her license. Physical therapy for a PARTICIPANT'S temporomandibular joint disorder is not covered under this paragraph.

41. TRANSPLANTATIONS, IMPLANTATIONS and GRAFTING.

a. TRANSPLANTATIONS. The following TRANSPLANTATIONS are covered by this CONTRACT. Donor expenses are covered when included as part of the PARTICPANT'S (as the transplant recipient) bill. Separately billed donor-related services are not covered under this CONTRACT.

(1) autologous (self to self) and allogeneic (donor to self) BONE MARROW TRANSPLANTATIONS and peripheral blood stem cell rescue and/or TRANSPLANTATIONS used only in the TREATMENT of:

(a) mydlodysplastic syndrome;

(b) homozygous Beta-Thalassemia;

(c) mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy);

(d) neuroblastoma;

(e) multiple Myeloma, Stage II or Stage III;

(f) germ Cell Tumors (e. g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound;

(g) aplastic anemia;

(h) acute leukemia;

(i) severe combined immunodeficiency, e.g., adenosine deaminase deficiency and idiopathic deficiencies;

(j) wiskott - Aldrich syndrome;

(k) infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);

(l) hodgkins' and non-Hodgkins' lymphoma;

(m) combined immunodeficiency;

(n) chronic myelogenous leukemia;

(o) pediatric tumors based upon individual consideration.

(2) Parathyroid TRANSPLANTATION.

(3) 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.

(4) Corneal TRANSPLANTATION (keratoplasty) limited to:

(a) corneal opacity;

(b) 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;

(c) corneal ulcer;

(d) repair of severe lacerations.

(5) Kidney.

b. **IMPLANTATIONS.** The following IMPLANTATIONS are covered by this CONTRACT:

(1) heart valve IMPLANTATION;

(2) pseudophakia (intraocular lens) IMPLANTATION;

(3) penile prosthesis IMPLANTATION;

(4) urethral sphincter IMPLANTATION;

(5) artificial breast IMPLANTATION;

(6) pacemaker;

(7) defibrillator;

(8) cochlear as required by Wis. Stat. §632.895 (16); and

(9) for the STANDARD PLAN in Section III, and IV, any other implant which WPS determines is medically necessary and not experimental.

c. **GRAFTINGS.** The following GRAFTINGS are covered by this CONTRACT:

(1) bone (non-cosmetic);

(2) skin (non-cosmetic);

(3) artery;

(4) arteriovenous shunt;

(5) blood vessel limited to blood vessel repair;

(6) cartilage (non-cosmetic);

(7) conjunctiva;

(8) fascia;

(9) lid margin (non-cosmetic);

(10) mucosa;

(11) bronchoplasty;

(12) coronary bypass;

(13) mucus membrane;

(14) muscle;

(15) nerve;

(16) pterygium;

(17) rectal (Thiersch operation);

(18) sclera;

(19) tendon;

(20) vein (bypass).

d. Exclusions.

(1) BENEFITS are not payable for any form of or SERVICES related to TRANSPLANTATION, IMPLANTATION or GRAFTING other than those specifically listed in this Section VII. This applies even if MEDICARE pays for any portion of the CHARGES.

(2) Examples of procedures that are not payable:

(a) heart TRANSPLANTATION;

(b) intestine TRANSPLANTATION;

(c) islet tissue (island of Langerhans-pancreas) TRANSPLANTATION;

(d) liver TRANSPLANTATION;

(e) lung TRANSPLANTATION;

(f) pancreas TRANSPLANTATION;

(g) bladder stimulator (pacemaker) IMPLANTATION;

(h) implantable or portable artificial kidney or other similar device;

(i) dental implants.

WPS MEDICAL MANAGEMENT PROGRAM

The PARTICIPANT must comply with the terms of this section in order to receive this PLAN'S full BENEFITS. This section does not apply to any PARTICIPANT for whom MEDICARE is the primary payor or for any confinements for pregnancy. Other plan limitations, exclusions and conditions are not affected by this section, and still apply.

Preadmission Certifications

For non-emergency admissions, a PARTICIPANT must notify WPS' Managed Care Department if his/her attending PHYSICIAN recommends that he/she be admitted to a: (1) HOSPITAL for TREATMENT of an ILLNESS or INJURY; or (2) RESIDENTIAL TREATMENT PROGRAM for TREATMENT of alcoholism, drug abuse or NERVOUS OR MENTAL DISORDERS. The PARTICIPANT must notify WPS at least three business days prior to the proposed admission date for non-emergency admissions.

The notice must be in writing or given by telephone by calling WPS at 1-800-333-5003
If a PARTICIPANT does not notify us as stated above, BENEFITS otherwise payable for his/her CONFINEMENT will be reduced by $100 for that CONFINEMENT.

Emergency admissions are not subject to the preadmission requirements described above. However, if the PARTICIPANT is admitted on an emergency basis, he/she should notify WPS within two business days of his/her admission date.

WPS will determine the number of MEDICALLY NECESSARY days for which BENEFITS are payable under the PLAN. No benefits are payable for CONFINEMENTS in a HOSPITAL or residential treatment program or any days which WPS determines are not MEDICALLY NECESSARY.

Even though the PARTICIPANT provides notification that does not guarantee that the PLAN will pay for the HEALTH CARE SERVICES. The PARTICIPANT still needs to be eligible for coverage on the date HEALTH CARE SERVICES are provided and those HEALTH CARE SERVICES must be MEDICALLY NECESSARY.

Prenatal and Maternity Care Notification

Maternity admissions are not subject to the preadmission and continued stay certification requirements described above. However, if a PARTICIPANT is pregnant, WPS requests that the PARTICIPANT also notifies WPS:

1. After the PARTICIPANT'S first prenatal visit, but no later than the PARTICIPANT'S 13th week of pregnancy; and

2. Within 24 hours or the first business day following the date of the PARTICIPANT'S delivery.

Although the PARTICIPANT'S failure to provide such notice won't reduce BENEFITS otherwise payable for such HEALTH CARE SERVICES, this notice to WPS will allow WPS to work with the PARTICIPANT and the PARTICIPANT'S PHYSICIAN during the pregnancy to help coordinate MEDICALLY NECESSARY HEALTH CARE SERVICES and provide high-risk screening and health information.

Disease Case Management

Disease case management (DCM) is a proactive approach to health care designed to prevent long-term and unnecessary complications of chronic disease through education, TREATMENT, and appropriate care. WPS' DCM program partners chronically-ill PARTICIPANTS and their HEALTH CARE PROVIDERS with WPS

Disease Case Management nurses to gain control over diseases such as diabetes, asthma, congestive heart failure, coronary artery disease, depression, addictive disorders, high-risk maternity, hypertension, and high cholesterol.

WPS identifies potential disease case management PARTICIPANTS either through our claims processing system or by referral from a number of sources, for example, a family member or HEALTH CARE PROVIDER. Once a PARTICIPANT is identified, one of WPS' nurses will telephone that PARTICIPANT to go through a clinical assessment and determine if the PARTICIPANT is interested in the program.

Education and support follow the initial assessment by phone or mail. WPS DCM nurses routinely check on health status, remind PARTICIPANTS about medications, share new information about a disease or TREATMENT, or follow up after office visits to ensure that the PARTICIPANT understands their PHYSICIAN'S instructions.

MEDICARE PLUS

Medicare Plus is designed to supplement, not duplicate, BENEFITS available under the federal MEDICARE program. It is designed for ANNUITANTS and is not available to active EMPLOYEES, their spouses or DEPENDENTS.

See the booklet "State Medicare Plus Health Care Benefit Plan" for a description of BENEFITS and other provisions of the PLAN. Additional information may be obtained by referring to "Your MEDICARE Handbook" published by the Social Security Administration.

1. Unless you are an active (non-retired) state EMPLOYEE, all family members must enroll in MEDICARE (both Part A - HOSPITAL and Part B - Medical) when first eligible. Otherwise, state group health coverage is subject to cancellation without the right of reinstatement. This requirement is deferred for active EMPLOYEES (and their DEPENDENTS) until the EMPLOYEE'S termination of state employment.

2. Those family members not eligible for MEDICARE will continue their Standard or SMP coverage.

3. Medicare Plus will provide uninterrupted coverage from Standard coverage or SMP.

4. Medicare Plus provides reimbursement for all DEDUCTIBLES under MEDICARE Part A (Hospitalization) and MEDICARE Part B (Medical) if you have incurred at least that DEDUCTIBLE amount in covered expenses during the CALENDAR YEAR.

5. Medicare Plus provides payment for prescribed or recommended SERVICES and SUPPLIES which may not be covered or fully covered by MEDICARE.

EXCLUSIONS

Except as otherwise specifically provided, this CONTRACT provides no BENEFITS for:

1. CUSTODIAL CARE or rest cures, wherever furnished, and care in custodial or similar institutions, a health resort, spa or sanitarium. This applies even if MEDICARE pays for any portion of the CHARGES.

2. Physical examinations or health checkups for informational purposes requested by third parties. Examples: physical exams required by schools, summer camp, employment, marriage, insurance, sports, etc.

3. SERVICES of a blood donor.

4. HEALTH CARE SERVICES for cosmetic or beautifying purposes, except to correct CONGENITAL bodily disorders or conditions or when MEDICALLY NECESSARY for TREATMENT of an ILLNESS or accidental INJURY.

5. Preparation, fitting or purchase of eye glasses or contact lenses, except as specifically stated in the PLAN; vision therapy, including orthoptic therapy and pleoptic therapy; or eye refractive surgery; hearing aids or examinations for their prescription, except as specifically covered under the PLAN.

6. TREATMENT of corns and calluses of the feet, toenails (except for complete removal), overgrowth of the skin of the feet, unless prescribed by a PHYSICIAN who is treating the PARTICIPANT for a metabolic or peripheral disease.

7. SERVICES of a dentist, including all orthodontic SERVICES, or SERVICES provided in the examination, repair or replacement of teeth, or in the extraction of teeth, dental implants, or TREATMENT for Temporomandibular Joint Disease (TMJ) other than recognized radical ORAL SURGERY, except as expressly provided in this CONTRACT. An accident caused by chewing is not considered an INJURY.

8. HEALTH CARE SERVICES:

- **a.** that 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.

9. HEALTH CARE SERVICES for any INJURY or ILLNESS eligible for coverage, or for which a PARTICIPANT receives, or which is the subject of, any award or settlement under a Worker's Compensation Act or any EMPLOYER liability law.

10. HEALTH CARE SERVICES for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.

11. HEALTH CARE SERVICES furnished by the U.S. Veterans Administration, except for such TREATMENT, SERVICES and supplies for which under this CONTRACT, this CONTRACT is the

primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.

12. HEALTH CARE SERVICES available from OTHER COVERAGE. Then, BENEFITS will be limited to the CHARGES for TREATMENT, SERVICES and supplies, less payments available from OTHER COVERAGE. Together, the total BENEFITS payable may not exceed the incurred CHARGES. In computing allowances available, the primary carrier according to Wis. Adm. Code § 3.40 will provide the full BENEFITS payable under its CONTRACT, with the other carrier processing the remainder of those CHARGES. However, when MEDICARE is primary, payment of BENEFITS is limited to the amount computed without coordination of BENEFITS, less the MEDICARE payments. The MEDICARE allowed amount on assigned claims is considered the CHARGE; on unassigned claims, the CHARGE is the MEDICARE limiting CHARGE amount.

If the PARTICIPANT is not actually enrolled in the voluntary medical insurance portion of MEDICARE when it is first available, the member's BENEFITS are limited to the extent they are entitled, or would be entitled if enrolled for MEDICARE BENEFITS.

13. Any BENEFITS under sections "Benefit Provisions", if the PARTICIPANT is eligible to enroll in MEDICARE. This exclusion is not applicable until the PARTICIPANT'S termination of employment with the State of Wisconsin.

14. PROFESSIONAL SERVICES not provided by a PHYSICIAN or any health care provider listed in the definition of PROFESSIONAL SERVICES in section "Definitions".

15. HEALTH CARE SERVICES which are not MEDICALLY NECESSARY or which aren't appropriate for the TREATMENT of an ILLNESS or INJURY, as determined by WPS.

16. Reversal of sterilization.

17. HEALTH CARE SERVICES which are EXPERIMENTAL or INVESTIGATIVE in nature, except for prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN and required to be administered by a professional provider described in Wis. Stats. § 632.895 (9) for TREATMENT of HIV.

18. HEALTH CARE SERVICES for, or leading to, sex transformation surgery and sex hormones related to such TREATMENT.

19. 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.

20. HEALTH CARE SERVICES provided by a midwife, except when provided in a clinic or hospital setting.

21. Food received on an OUTPATIENT basis or food supplements.

22. Housekeeping, shopping or meal preparation SERVICES.

23. HEALTH CARE SERVICES in connection with obesity, weight reduction or dietetic control, except for morbid obesity and disease etiology.

24. Retin-A, Minoxidil, Rogaine or their medical equivalent in the topical application form, unless MEDICALLY NECESSARY.

25. HEALTH CARE SERVICES used in educational or vocational training or testing, except as specifically stated in the PLAN.

26. HEALTH CARE SERVICES in connection with any ILLNESS or INJURY caused by a PARTICIPANT'S: (a) engaging in an illegal occupation; or (b) commission of, or an attempt to commit, a felony.

27. Motor vehicles; lifts for wheelchairs and scooters; and stair lifts.

28. HEALTH CARE SERVICES for which the PARTICIPANT has no obligation to pay.

29. HEALTH CARE SERVICES rendered by a member of a PARTICIPANT'S IMMEDIATE FAMILY or a person who resides in the PARTICIPANT'S home.

30. Routine periodic maintenance of covered DURABLE MEDICAL EQUIPMENT, such as, replacement batteries.

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

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

33. Over-the-counter drugs.

34. Prescription drugs and BIOLOGICALS prescribed in writing by a PHYSICIAN for TREATMENT of an ILLNESS or INJURY and dispensed by a licensed pharmacist. For purposes of this exclusion, "prescription drug" means drugs that are dispensed by a written prescription from a PHYSICIAN, under Federal law, approved for human use by the Food and Drug Administration and dispensed by a pharmacist.

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

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

37. HEALTH CARE SERVICES to the extent the PARTICIPANT is eligible for MEDICARE BENEFITS, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if MEDICARE is the primary payor.

38. That portion of the amount billed for a health care service covered under the Plan that exceeds WPS' determination of the CHARGE for such health care service.

39. Supportive care.

40. Telephone, computer or internet consultations between a member and any HEALTH CARE PROVIDER.

41. Indirect services provided by health care providers for services such as, but are not limited to: creation of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; and reviewing quality assurance data.

42. Orthopedic shoes.

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

INDIVIDUAL TERMINATION OF COVERAGE

1. A PARTICIPANT'S coverage shall terminate at the end of the month on the earliest of the following dates:

a. The EFFECTIVE DATE of change to another health care plan through the BOARD approved enrollment process.

b. The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. Pursuant to Federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the PLAN'S requirement for the amount that must be paid. However, the PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period.

c. The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage, while on a leave of absence or LAYOFF, as required by state and federal law.

d. The end of the month in which a notice of cancellation of coverage or sick leave escrow application is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT or CONTINUANT, or a later date as specified on the cancellation of coverage notice or sick leave escrow application.

e. The definition of PARTICIPANT no longer applies (such as a dependent child's marriage, divorced spouse, end of a domestic partnership, etc.). If FAMILY COVERAGE remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification of continuation of coverage rights occurs. The EMPLOYER may collect PREMIUM retroactively from the SUBSCRIBER if the divorce was not reported in a timely manner and there were no other eligible DEPENDENTS for FAMILY COVERAGE to remain in effect.

f. The expiration of the continuation period for which the PARTICIPANT is allowed to continue under paragraph 4. below, of this subsection.

g. The EFFECTIVE DATE of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any pre-existing condition of PARTICIPANT who continues under paragraph 4. of this section.

h. The earliest date Federal or State continuation provisions permit termination of coverage for any reason.

i. The end of the month in which the SUBSCRIBER terminates employment.

2. No refund of any PREMIUM may be made unless the EMPLOYER, or DEPARTMENT if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month for which PREMIUM has been collected or deducted. Except, for State of Wisconsin EMPLOYEES, when coverage ends by reason of termination of employment, then refunds shall be made back to the end of the month in which employment terminates.

3. Except when a PARTICIPANT'S coverage terminates because of cancellation or non-payment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if confined as an INPATIENT, but only until the attending PHYSICIAN determines that CONFINEMENT is no longer MEDICALLY

NECESSARY, the CONTRACT maximum is reached, the end of 12 months after the date of termination, or CONFINEMENT ceases, whichever occurs first.

4. **a.** Except when coverage is cancelled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the EMPLOYER is not notified of the PARTICIPANT'S loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the EMPLOYER notice, whichever is later. Application must be post-marked within 60 days of the date the PARTICIPANT is notified of the right to continue or 60 days from the date coverage ceases, whichever is later. WPS shall bill the continuing PARTICIPANT directly for the required PREMIUMS. WPS may not apply an administrative surcharge to the PREMIUM, even if otherwise permitted under state or federal law.

b. Such PARTICIPANT may also elect to convert to individual coverage, without underwriting, if application is made directly to the PLAN within 30 days after termination of group coverage as provided under Wis. Stat. 632.897. The PARTICIPANT shall be eligible to apply for the direct pay conversion contract then being issued provided coverage is continuous and the PREMIUMS then in effect for the conversion contract are paid without lapse. The PLAN must notify a PARTICIPANT at least 60 days prior to loss of eligibility for COBRA coverage and will also notify the PARTICIPANT of other available options including the availability of conversion coverage and HIRSP. This does not include termination of coverage due to non-payment of PREMIUM. The right to a conversion contract will also be offered when the PARTICIPANT reaches the maximum length of continuation for group coverage.

5. Children born or adopted while the parent is continuing group coverage may be covered for the remainder of the parent's period of continuation. A PARTICIPANT who has SINGLE COVERAGE must elect FAMILY COVERAGE within 60 days of the birth or adoption in order for the child to be covered. The PLAN will automatically treat the child as a qualified DEPENDENT as required by COBRA and provide any required notice of COBRA rights.

6. No person other than a PARTICIPANT is eligible for health BENEFITS. The SUBSCRIBER'S rights to group health coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an EMPLOYER where coverage is available and is limited to the STANDARD PLAN.

Change to an alternate plan via dual-choice enrollment is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

7. In situations where a PARTICIPANT in an alternate health plan has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory PHYSICIAN-patient relationship with the current or alternate primary care PHYSICIAN, disenrollment efforts may be initiated by the PLAN or the BOARD. The SUBSCRIBER'S disenrollment is the beginning of the month following completion of the grievance process and approval of the BOARD. Coverage will be transferred to the STANDARD PLAN, with options to enroll in alternate health care plans during subsequent dual-choice enrollment periods. Re-enrollment in the alternate plans is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

GENERAL CONDITIONS

BENEFITS are available in accordance with the terms, conditions and provisions of this CONTRACT, including:

1. No provision of this CONTRACT shall interfere with the professional relationship between a PARTICIPANT and PHYSICIAN.

2. If a PARTICIPANT remains in an institution after being advised by the attending PHYSICIAN that further CONFINEMENT is medically unnecessary, the PARTICIPANT will be solely responsible to the institution for all expenses incurred after being so advised. WPS or the BOARD may at any time request the attending PHYSICIAN to certify that further CONFINEMENT is MEDICALLY NECESSARY.

3. Each PARTICIPANT is free to select and/or discharge a PHYSICIAN. A PHYSICIAN is free to provide SERVICE or not, in accordance with the custom in private practice of medicine. Nothing in this CONTRACT obligates WPS or the BOARD to provide a PHYSICIAN to treat any PARTICIPANT.

4. Each PARTICIPANT agrees to conform to the rules and regulations of the institution in which he/she is an INPATIENT, including those rules governing admissions and types and scope of SERVICES furnished by the institution.

5. As a condition of entitlement to receive BENEFITS, each PARTICIPANT authorizes any person or institution to furnish to WPS all medical and surgical reports and other information as WPS may request.

6. WPS and the BOARD each have the right and opportunity to have a PARTICIPANT examined by PHYSICIANS of their choice when and as often as they may reasonably require.

7. The PARTICIPANT'S identification card must be presented, or the fact of the PARTICIPANTS participation under this CONTRACT be made known, to the provider when the PARTICIPANT requests care or SERVICES.

8. If a PARTICIPANT fails to comply with G. above, then written notice of the commencement of TREATMENT or CONFINEMENT must be given to WPS within 30 days after the commencement of TREATMENT or CONFINEMENT. Failure to give that notice will not invalidate or reduce any claim if it is shown that notice was given as soon as was reasonably possible. However, no BENEFITS will be paid for CHARGES incurred in any CALENDAR YEAR unless a claim for those CHARGES is received by WPS within 24 months from the date the SERVICE was rendered.

9. Each PARTICIPANT agrees to reimburse WPS or the BOARD for all payments made for BENEFITS to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the PARTICIPANT by WPS or the BOARD. At the option of WPS or the BOARD, BENEFITS for future CHARGES may be reduced by WPS as a set off toward reimbursement. Acceptance of PREMIUMS or paying BENEFITS for CHARGES will not constitute a waiver of the rights of WPS or the BOARD to enforce these provisions in the future.

10. Each PARTICIPANT agrees to use a medical claim form when submitting claims for medical BENEFITS that are not submitted to WPS by the provider. Only itemized bills, statements acknowledging actual receipt of payment, or similar receipts may serve as proof of claim. Each must be an official document from the provider. Cash register receipts that are not itemized or do not clearly identify the provider, canceled checks, custom order forms and balance due statements alone are NOT acceptable as proof of claim.

Each itemized bill statement or receipt must include the patient's name, patient's WPS identification number, provider's name, provider's address, date(s) of SERVICE, diagnosis and diagnostic code, procedure code, and CHARGE for each date of SERVICE and is an official document from the provider.

For medical claims incurred outside of the United States, the PARTICIPANT must obtain information on foreign currency exchange rates at the time CHARGES were incurred and an English language itemized billing to facilitate claim processing.

11. WPS will, at its option, pay BENEFITS either to the provider of SERVICES or to the PARTICIPANT.

12. Each PARTICIPANT agrees that the BOARD is subrogated to the PARTICIPANT'S rights to damages for an ILLNESS or INJURY caused by any act or omission of any third person to the extent of BENEFITS.

13. A PARTICIPANT shall not commence any action to recover any BENEFITS or enforce any rights under this CONTRACT until 60 calendar days have elapsed since written notice of claim was given by the PARTICIPANT to WPS, nor will any action be brought more than three years after the SERVICES have been provided.

14. Any provisions of the CONTRACT which may be prohibited by law are void, but will not impair any other provision.

15. WPS or a PARTICIPANT'S PHYSICIAN may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment program if it appears that:

a. the recommended TREATMENT offers at least equal medical therapeutic value; and

b. the current TREATMENT program may be changed without jeopardizing the PARTICIPANT'S health; and

c. the CHARGES incurred for SERVICES provided under the recommended TREATMENT will probably be less.

If WPS agrees to the PHYSICIAN'S recommendation or if the PARTICIPANT or his/her authorized representative and the attending PHYSICIAN agree to WPS' recommendation, the recommended TREATMENT will be provided as soon as it is available.

BENEFITS payable for the CHARGES incurred for such SERVICES shall be paid according to the terms and conditions of this CONTRACT. If the recommended TREATMENT includes SERVICES for which BENEFITS are not otherwise payable, payment of BENEFITS will be as determined by WPS.

16. WPS may recommend that an INPATIENT be transferred to another institution if it appears that:

a. the other institution is able to provide the necessary medical care; and

b. the physical transfer would not jeopardize the PARTICIPANT'S health or adversely affect the current course of TREATMENT; and

c. the CHARGES incurred at the succeeding institution will probably be less than those CHARGES at the prior institution.

If the PARTICIPANT or his/her authorized representative and the attending PHYSICIAN agree to the transfer, the transfer will take place as soon as bed space is available.

17. The CONTRACT contains the following provision:

"Disputes as to CHARGES shall be referred, on a timely basis, to WPS who shall actively attempt to settle the dispute with the provider in a reasonable time frame.

If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT shall contact the DEPARTMENT or WPS within 14 DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two BUSINESS DAYS of WPS becoming aware of a lawsuit, WPS shall notify the DEPARTMENT about the lawsuit. The DEPARTMENT shall advise WPS to either to attempt to resolve the lawsuit or hire an attorney to undertake the defense of such a lawsuit for the PARTICIPANT. WPS shall hire outside legal counsel to represent that PARTICIPANT in any lawsuit involving WPS' determination of the CHARGE for a covered health care service under the HEALTH BENEFIT PLAN and to undertake the defense of such a lawsuit for the PARTICIPANT or take such other measures as WPS deems necessary to resolve the dispute. However, it is understood and agreed that WPS shall not hire outside legal counsel to represent that PARTICIPANT and undertake the defense of any such lawsuit or take any other measures to protect the PARTICIPANT if the PARTICIPANT agrees to accept responsibility for any costs in excess of the CHARGE determined by WPS."

While in the great majority of cases PHYSICIANS accept the WPS payment as reasonable, a PARTICIPANT may on occasion be asked by the PHYSICIAN to agree verbally or to sign an agreement accepting the responsibility for any CHARGES in excess of those paid by WPS. PARTICIPANTS should understand that such a verbal or written agreement about fees with the provider will forfeit full protection under the CONTRACT.

CHARGES in excess of what WPS determined to be "reasonable" will appear on your Explanation of Benefits (EOB) statement.

If your PHYSICIAN or HOSPITAL bills you for any remaining balance in excess of the reasonable amount, you should:

a. send all bills you may receive for balances above the reasonable payments made by WPS to the WPS office immediately. Continue sending WPS all such bills you receive. This is the means by which WPS is notified that you are continuing to be billed for the remaining balance.

b. call WPS immediately if you receive notice that such a balance has been referred for legal action or to a credit or collection agency (see CONTRACT language above).

You are not responsible for paying CHARGES in excess of what WPS determines as reasonable unless you have made an agreement with the service provider to accept this liability.

18. In addition to the continuity of care provisions under Wis. Stat. § 609.24, the following provider guarantee provision applies. HEALTH CARE PROVIDERS listed on any of the PLAN'S publications of providers, including subcontracted providers, are either under contract and available as specified in such publications for all of the ensuing calendar year or the PLAN will pay charges for benefits on a fee-for-service basis. Fee-for-service basis means the usual and customary charges the PLAN is able to negotiate with the HEALTH CARE PROVIDER while the SUBSCRIBER is held harmless and indemnified. The intent of this provision is to allow patients of PLAN HEALTH CARE PROVIDERS to continue appropriate access to any PLAN HEALTH CARE PROVIDER until the PARTICIPANT is able to change PLANS through the next dual-choice enrollment. This applies in the event a HEALTH CARE PROVIDER or provider group terminates its contract with the PLAN, except that loss of physicians due to normal attrition (death, retirement, a move from the service area) or as a result of a formal disciplinary action relating to quality of care shall not require fee-

for-service payment. HEALTH CARE PROVIDERS also agree to accept new patients unless specifically indicated otherwise. When HEALTH CARE PROVIDERS terminate their contractual relationship, SUBSCRIBERS must be notified by the PLAN prior to the dual-choice enrollment period. The PLAN shall keep a record of this notification mailing and shall provide documentation, by SUBSCRIBER and indicating the mailing address used, upon the DEPARTMENT'S request.

CLAIM DETERMINATION AND GRIEVANCE PROCEDURE

WPS will send the PARTICIPANT written notice regarding the claim within 30 days of receiving the claim, unless special circumstances require more time. This notice explains the reason(s) for payment or non-payment of a claim. If a claim is denied because of incomplete information, the notice indicates what additional information is needed. The PARTICIPANT may contact WPS Member Service department for more details of the decision.

If any PARTICIPANT has a problem or complaint relating to a BENEFIT determination, he/she should contact WPS. WPS will assist the PARTICIPANT in trying to resolve the matter on an informal basis, and may initiate a Claim Review of the BENEFIT determination. If the PARTICIPANT wishes, he/she may omit this step and immediately file a formal GRIEVANCE.

Claim Review

A claim review may be done only when a PARTICIPANT requests a review of denied BENEFITS. When a claim review has been completed, and the decision is to uphold the denial of BENEFITS, the PARTICIPANT will receive written notification as to the specific reason(s) for the continued denial of BENEFITS and of his/her right to file a GRIEVANCE.

EXPEDITED GRIEVANCE

Appeals related to an urgent health concern (i.e., life threatening), will be handled within 72 hours of WPS' receipt of the GRIEVANCE.

Formal GRIEVANCE

To submit a GRIEVANCE, the PARTICIPANT (or the PARTICIPANT'S authorized representative) must submit it in writing to WPS and identify it as a GRIEVANCE. In addition, the PARTICIPANT should also include the following information:

1. The date of service, the patient's name, amount and any other identifying information such as claim number or health care provider, as shown on the denial; and

2. Any other pertinent information such as the identification number, patient's name, date and place of service, and reason for requesting review.

PARTICIPANTS have three years after receiving our initial notice of denial or partial denial of your claim to file a grievance.

Except for an EXPEDITED GRIEVANCE, WPS will acknowledge receipt of the GRIEVANCE within 5 business days of receipt. WPS will inform the PARTICIPANT, in writing, of when the GRIEVANCE will be heard by the GRIEVANCE committee at least seven (7) calendar days prior to the date of the meeting.

The PARTICIPANT (or the PARTICIPANT'S authorized representative) will have the right to appear in person before the GRIEVANCE committee or by teleconference to present written or oral information. If the PARTICIPANT (or the PARTICIPANT'S authorized representative) chooses to participate in the GRIEVANCE committee hearing, WPS must be notified no less than four (4) business days prior to the date of the meeting.

WPS will review the GRIEVANCE. WPS will provide a written decision, including reasons, within 30 calendar days of receiving the GRIEVANCE. If special circumstances require a longer review period, before the 30 calendar day period has expired, WPS will notify the PARTICIPANT that an additional 30 calendar days will be needed to review the GRIEVANCE citing the reason additional time is needed and when resolution will be expected.

RIGHTS AFTER GRIEVANCE

There are potentially two avenues of further review available to the PARTICIPANT after WPS' final GRIEVANCE decision.

1. Group Insurance Board Administrative Review Process (ETF Chapter 11, Wis. Administrative Code)

The DEPARTMENT will not issue a determination that can be resolved through the independent review process under Wis. Stat. §632.835 and Wis. Adm. Code §INS 18.11.

Determinations will not be issued for denied BENEFITS based on any of the following:

(a) medical necessity;

(b) appropriateness;

(c) health care setting;

(d) level of care;

(e) effectiveness of a covered benefit;

(f) experimental treatment;

(g) **p**re-existing condition; or

(h) rescission of a policy or certificate.

WPS' final GRIEVANCE decision may be reviewed by the DEPARTMENT provided the written request for the review is received by the DEPARTMENT within 60 days after WPS' final GRIEVANCE decision letter is sent to the PARTICIPANT. Decisions not timely appealed to the DEPARTMENT are final. Send requests to:

Department of Employee Trust Funds
Attn: Quality Assurance Services Bureau
801 West Badger Road
P.O. Box 7931
Madison, WI 53707-7931

2. External Review by an Independent Review Organization

You can request an independent review if:

a. you were denied coverage for a HEALTH CARE SERVICE because WPS has determined that the HEALTH CARE SERVICE is not MEDICALLY NECESSARY;

b. you were denied coverage for a HEALTH CARE SERVICE because WPS has determined that the HEALTH CARE SERVICE is EXPERIMENTAL or INVESTIGATIVE;

c. you disagree with WPS' determination regarding the diagnosis and level of service for TREATMENT of autism; or

d. you disagree with WPS' determination denying or terminating TREATMENT or payment for TREATMENT on the basis of a preexisting condition exclusion.

To qualify for EXTERNAL REVIEW, the PARTICIPANT'S claim must involve one of the determinations stated above.

In either case, the TREATMENT must cost more than the amount specified by the OCI or the Patient Protection and Affordable Care Act in order to qualify for EXTERNAL REVIEW.

If the PARTICIPANT wishes to pursue EXTERNAL REVIEW instead of a review by the Department of Employee Trust Funds, the PARTICIPANT or the PARTICIPANT'S authorized representative must notify WPS' Appeal Department in writing at the following address:

WPS Health Insurance
Attention: IRO Coordinator
P.O. Box 7458
Madison, WI 53708

WPS must receive the request within four months of the date of the PARTICIPANT'S GRIEVANCE decision letter.

If a PARTICIPANT or his/her authorized representative wish to file a request for an independent review, the PARTICIPANT'S request must be submitted in writing to the address listed above and received within four months of the decision date of the PARTICIPANT'S grievance. Within five days of WPS' receipt of his/her request, an accredited IRO will be assigned to the PARTICIPANT'S case through an unbiased random selection process. The assigned IRO will send the PARTICIPANT a notice of acceptance within one business day of receipt, advising the PARTICIPANT of his/her right to submit additional information within ten business days of his/her receipt of the notice from the IRO. The assigned IRO will also deliver a notice of the final external review decision in writing to the PARTICIPANT and WPS within 45 calendar days of their receipt of the request. A decision made by an IRO is binding for both the PARTICIPANT and the PLAN with the exception of pre-existing condition exclusions. The PARTICIPANT is not responsible for the costs associated to the IRO. In addition, some of the information a PARTICIPANT provides may be shared with appropriate regulatory authorities.

There are certain circumstances in which the PARTICIPANT may be able to skip the GRIEVANCE process and proceed directly to EXTERNAL REVIEW. Those circumstances are as follow:

a. WPS agrees to proceed directly to EXTERNAL REVIEW, or

b. The PARTICIPANT'S situation requires an EXPEDITED REVIEW.

If the PARTICIPANT'S situation requires an EXPEDITED REVIEW:

a. WPS will notify the INDEPENDENT REVIEW ORGANIZATION and the Department of Employee Trust Funds within one day and send them the PARTICIPANT'S information.

b. The INDEPENDENT REVIEW ORGANIZATION will review the material, normally within two business days, and will request additional information, if necessary. WPS will have two business days to respond to this request.

c. Once the INDEPENDENT REVIEW ORGANIZATION has all the necessary information, it will render a decision, normally within 72 hours.

The decision of the INDEPENDENT REVIEW ORGANIZATION is binding to both WPS and the PARTICIPANT as per contract. Once the INDEPENDENT REVIEW ORGANIZATION decision is issued, the PARTICIPANT has no further rights to review by the Department of Employee Trust Funds.

The PARTICIPANT cannot request a review of WPS' final appeal decision by both an INDEPENDENT REVIEW ORGANIZATION and the Department of Employee Trust Funds simultaneously. Once an INDEPENDENT REVIEW ORGANIZATION has begun the process to review a case, the DEPARTMENT will suspend its process. The INDEPENDENT REVIEW ORGANIZATION'S decision is binding on all parties and cannot be further appealed. If the INDEPENDENT REVIEW ORGANIZATION rejects the request for review of the ADVERSE DETERMINATION involving MEDICAL NECESSITY or EXPERIMENTAL TREATMENT denial on the ground of jurisdiction, then the DEPARTMENT will continue its process.

MISCELLANEOUS INFORMATION

How To File A Claim

1. Present your WPS identification card to the PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER when a covered SERVICE is received. The HEALTH CARE PROVIDER may submit the claim directly to WPS or MEDICARE. If the HEALTH CARE PROVIDER declines to submit the claim, you should obtain an itemized billing statement and forward it together with your identification numbers to WPS for processing.

2. For medical BENEFITS not submitted by the HEALTH CARE PROVIDER to WPS, you must use a medical claim form. You may obtain this form from WPS. Save your itemized bills or statements for all covered medical SERVICES. All receipts and bills must be fully itemized. Cash register receipts, canceled checks and balance due statements are not acceptable. Receipts and bills must be originals.

3. Be sure that all receipts and bills include: the patient's name and identification number; provider's name and address; date(s) of service, diagnosis and diagnostic code and procedure code; the charge for each date of service. Be sure to use a separate claim form for each family member for each CALENDAR YEAR. After subtracting the DEDUCTIBLE and COINSURANCE, WPS will process the balance of the CHARGES.

4. For SERVICES outside of Wisconsin, the HOSPITAL or PHYSICIAN can verify your coverage in out of state emergencies by calling WPS toll free during regular business hours.

5. Payment is made for reasonable CHARGES incurred anywhere in the United States or Canada. WPS will determine reasonable CHARGES for appropriate MEDICAL SERVICES or other items required while you are traveling in other countries. Obtain information on foreign currency exchange rates at the time CHARGES were incurred and an English language itemized billing to facilitate processing of your claim when you return home.

6. MEDICARE eligible PARTICIPANTS should include a copy of MEDICARE'S Explanation of Benefits along with the appropriate claim form and receipts. Claims may also be forwarded directly from MEDICARE to WPS. Please see subsection "MEDICARE Cross-Over" below.

MEDICARE Cross-Over

WPS has an agreement with MEDICARE to cross-over claims for any SERVICES that MEDICARE processed as primary. MEDICARE will automatically forward your Explanation of MEDICARE Benefits (EOMB) to WPS for SERVICES you receive throughout the United States.

Cross-over applies to both MEDICARE Part A and B claims. It is designed to eliminate some of the paperwork involved in filing claims, therefore you will not need to send copies of your EOMB to WPS to receive BENEFITS under the PLAN.

Automatic claim forwarding is automatic for each person covered under MEDICARE. You do not need to complete a form or contact WPS to take advantage of cross-over.

Provider Directory

You can access HEALTH CARE PROVIDERS, HOSPITALS, specialists and more through WPS' interactive and easy-to-use online Provider Directory. It's updated regularly to offer you the most current listing of HEALTH CARE PROVIDERS in your network. Simply follow these instructions to locate the HEALTH CARE PROVIDERS of your choice:

1. Access the WPS website at www.wpsic.com/state;

2. Click the "Find a Doctor" tab found on the top center side of the page, then follow these instructions:

- **a.** Select the network you're interested in, that is the Statewide/National (PPP) network.
- **b.** Select your network on the lower part of the page by clicking under "Find a Doctor", "Locate Providers in Wisconsin or in States Bordering Wisconsin", "Locate Providers for All Other Areas", or under "National Network." For providers outside of Wisconsin, but in adjacent counties, you may select either option.
- **c.** Enter the search criteria to find your doctor. You can search by doctor's name, specialty, or location. Use the look-up buttons for the best search results, then click the "Continue" button.
- **d.** Read the disclaimer, then click "Continue to Search Results" to view your search results.
- **e.** On the Search Results page, you'll find a listing of the providers, contact information, addresses, directions and the networks they are part of. You can either print these pages to have them formatted in a PDF directory by clicking the applicable link near the top of your Search Results page.
- **f.** If your search did not yield the results you were looking for, try another search with broader criteria. For example: if you are looking for a general PHYSICIAN (no specialty), search using the criteria "family practice" or "internal medicine" and enter a city or county. Or, to find a particular HOSPITAL or facility, type the word "HOSPITAL" in the specialty area, then enter a city or county.

If you have questions, prefer a hard copy of your provider directory, or do not have access to a computer, please contact Member Services at (800) 634-6448.

Coordination of Benefits

The insurance industry has developed a standard policy provision called Coordination of Benefits (COB) which applies when there is duplicate coverage. Your HEALTH PLAN contains a coordination of benefits provision. When both husband and wife are working, members of the family are often covered by more than one group medical plan. COB provides that your BENEFITS will be "coordinated" with the benefits to which you or one of your eligible DEPENDENTS may be entitled to receive from another group plan or any governmental program. The purpose of COB is to allow you to receive up to 100% of covered medical expenses from all group plans combined - but no more. Please see exclusion #12. under section "Exclusions".

Understanding Your Explanation of Benefits (EOB)

The Explanation of Benefits (EOB) is a summary of how CHARGES were processed under your health PLAN for each covered family member. To simplify your record keeping, WPS lists only one HEALTH CARE PROVIDER and one patient on each EOB. this will allow you to easily match the EOB with your HOSPITAL, doctor or clinic bill. It's always wise to keep a copy of your EOB for your records. While the EOB is straightforward and easy to read, the first few times you look at it may be somewhat overwhelming. That is why WPS has created the following sample EOB form and corresponding explanation of the most pertinent information.

WPS HEALTH INSURANCE®

Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway - Box 8190 - Madison, WI 53708

EXPLANATION OF BENEFITS
THIS IS NOT A BILL - SAVE FOR YOUR RECORDS
Printed on 08/19/2010 Page 2 of 3

Questions?
Call 800-221-5313 or 608-221-1600
TTY/TTD Call 800-351-9945 or 608-222-1879

A DETAIL INFORMATION
(See Remarks for Definitions)

6 **Claim #:** 923911890
5 **Process Date:** 09/02/09
2 **Member #:** 000000000
4 **Group-Division #:** 123456-00001
1 **Member Name:** SMITH, WILLIAM
3 **Group Name:** ABC SUPPLY COMPANY
7 **Patient Name:** SMITH, JOHN
8 **Patient Account:** 11111111

9 Services Provided By / Date of Service / Servicing Provider	10 Service Dates From	To	11 Total Billed	12 Provider Discount	13 Amount Not Covered	14 Your Copay	15 Your Deductible	16 Your Coinsurance	17 Paid	18 WPS Paid	19 Other Insurance	20 See Remarks
MID MI REG MED-CLARE												
450-EMERG	08/14/09	08/14/09	20.00	3.06	0.00	16.94	0.00	0.00		0.00		TQ, OV
450-EMERG	08/14/09	08/14/09	40.00	6.12	0.00	33.88	0.00	0.00		0.00		TQ, OV
450-EMERG	08/14/09	08/14/09	422.00	64.57	0.00	49.18	0.00	0.00	100	308.25		TQ, OV
250-DRUGS	08/14/09	08/14/09	3303.63	505.46	0.00	0.00	0.00	279.82	90	2518.35		TQ
Payment To Provider On 09-08-09												
		CLAIM TOTALS:	**$3785.63**	**$579.21**	**$0.00**	**$100.00**	**$0.00**	**$279.82**		**$2826.60**	**$0.00**	

B

	Total Billed	Provider Discount	Amount Not Covered	Your Copay	Your Deductible	Your Coinsurance	WPS Paid	Other Insurance	What You Owe
STATEMENT TOTALS:	$3785.63	$579.21	$0.00	$100.00	$0.00	$279.82	$2826.60	$0.00	$379.82

C REMARKS

Remarks	Code	Explanation
TQ	45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THANK YOU FOR USING A CONFINITY PREFERRED PROVIDER. THIS AMOUNT IS A DISCOUNT USING A SPECIAL CONTRACT RATE FOR THIS SERVICE PROVIDED BY THIS PROVIDER. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT
OV	3	CO-PAYMENT AMOUNT. THIS SERVICE HAS A PER VISIT DEDUCTIBLE OR COPAY WHICH IS THE PATIENT'S RESPONSIBILITY.

D WHAT I NEED TO KNOW FOR MY NEXT CLAIM
(FOR THE PERIOD 1/1/2010 - 12/31/2010)

Benefit	Benefit Amount	Amount Met	Remaining
Individual In-Network Deductible	500.00	0.00	500.00
Individual In-Network Out-of-Pocket	1000.00	381.37	618.63
Individual Out-of-Network Deductible	500.00	0.00	500.00
Individual Out-of-Network Out-of-Pocket	1500.00	381.37	1118.63
Lifetime Maximum Benefit	2,000,000.00	11,330.47	1,988,669.53

Benefit status is current as of the time of printing. These amounts may be subject to outstanding adjustments.

E DID YOU KNOW?

The Member Health Center at www.wpsic.com provides action-oriented tools and information that you can use in the day-to-day management of chronic conditions like asthma and diabetes. Visit the WPS website today to learn more!

A Detail Information

Provides details on each medical service provided.

1. **Member Name:** The person insured by WPS (policyholder).
2. **Member Number:** Number associated with each member, shown on your WPS ID card.
3. **Group Name:** Employer Name (if covered under a group plan) or Individual Plan Name (if covered under an individual plan).
4. **Group-Division Number:** Unique code identifying your health plan in our claims system.
5. **Process Date:** The date WPS processed this claim.
6. **Claim Number:** Unique code identifying the claim submitted.
7. **Patient Name:** Lists the person(s) who received health care services.
8. **Patient Account:** Unique health care provider code identifying the patient treated.
9. **Services Provided By:** The provider that performed the procedure, plus the code and general category of the procedure performed.
10. **Service Dates:** The start and end date during which the listed procedure was performed.
11. **Total Billed:** The total cost of the procedure, as billed by the provider.
12. **Provider Discount:** The discount WPS negotiated with your provider, which will be subtracted from the total cost. Usually based on contractual agreements between WPS and providers in your WPS network.
13. **Amount Not Covered:** The portion of the total cost not covered under your health plan. This portion is your responsibility. See Remarks codes in the last column and the Remarks box for explanation.
14. **Your Copay:** The portion of the total cost you are responsible to pay before any deductible or coinsurance is applied for certain covered services (e.g., office visits).
15. **Your Deductible:** The portion of total cost applied to your deductible. (Your deductible is the amount of covered charges you must pay each calendar year before WPS pays benefits).
16. **Your Coinsurance:** The balance of total cost after subtracting provider discount, ineligible amount, copay, and deductible.
17. **Paid at %:** The percentage of the coinsurance amount paid by WPS.
18. **WPS Paid:** The portion of the coinsurance WPS paid.
19. **Other Insurance:** The portion of the coinsurance paid by another insurance plan (e.g., auto insurance).
20. **See Remarks:** The procedure performed may have triggered additional comments that do not fit in the chart. Match the Remarks code to those in the Remarks box under the chart to view the specific comment.

B Statement Totals

A summary of total charges billed by health care providers, negotiated provider discounts, WPS' financial responsibility and yours. What you owe is the portion of coinsurance you are responsible to pay. Includes copay, deductible, coinsurance, and any amount not covered. Paid directly to your provider, who will send you a bill.

C Remarks

Includes explanations of any Remarks codes listed in the See Remarks column.

D What I Need To Know For My Next Claim

Lists your plan's deductible, out-of-pocket maximum, and individual lifetime benefit; shows the amount of each you've met year-to-date; and the amount remaining.

E Did You Know?

Tips and announcements to help you get the most out of your benefit plan.

Please consult your Member Guide for more detailed definitions of these terms. If you have any questions, please contact Member Services at the number listed on the back of your WPS ID card.

PHARMACY BENEFIT MANAGER (PBM)

PBM SCHEDULE OF BENEFITS

The following description of the pharmacy benefit program is an excerpt from parts of Uniform Benefits that now apply to your prescription drug coverage. This is printed here for your convenience. A complete description of benefits, exclusions and limitations can be found on the ETF website http://etf.wi.gov/members/IYC2016/IYC_Cert_of_Cov2107.pdf) under section I. Schedule of Benefits, and section III. Benefits and Services D. Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM). Exclusions and limitations are found under IV #10. All benefits are paid according to the terms of Uniform Benefits.

All benefits are paid according to the terms of the Master Contract between the PBM and Group Insurance Board. The Schedule of Benefits describes certain essential dollar limits of your coverage and certain rules, if any, you must follow to obtain covered services.

The Group Insurance Board has decided to utilize a PBM to provide prescription drug benefits. The PBM will be responsible for the prescription drug benefits as provided for under the pharmacy benefit terms and conditions of the Uniform Benefits. The prescription drug benefits are dependent on your being covered under the State of Wisconsin group health program.

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

1. Prescription Drugs and Insulin:

- **a.** Level 1 - copayment for formulary prescription drugs - $5.00. Level 1 consists of formulary generic and certain low cost brand name drugs.
- **b.** Level 2 - copayment for formulary prescription drugs – 20% up to a $50.00 maximum per fill. Level 2 consists of formulary brand name and certain higher cost generic drugs.
- **c.** Level 3 - copayment for non-formulary prescription drugs – 40% up to a $150 maximum per fill.
- **d.** Level 4 Preferred - copayment for specialty preferred prescription drugs – 40% up to a $200.00 maximum per fill.
- **e.** Level 4 Non-preferred - copayment for specialty non-preferred prescription drugs – 40% up to a $200.00 maximum per fill.

2. Annual Out-of-Pocket Maximum (The Amount You Pay for Your Prescription Drugs and Insulin):

- **a.** Level 1 and Level 2: $1,000.00 per individual, $2,000.00 per family
- **b.** Level 3: $6, 350.00 per individual, $13,700.00 per family
- **c.** Level 4 (all): $1,200.00 per individual, $2,400.00 per family

3. Disposable Diabetic Supplies and Glucometers:

Coinsurance - Payable at 80%, which will be applied to the prescription drug annual out-of-pocket maximum.

4. Smoking Cessation:

Limited to one consecutive three-month course of pharmacotherapy covered per calendar year.

The PLAN, not the Pharmacy Benefit Manager, will be responsible for covering prescription drugs required to be administered during home care, office setting, confinement, emergency room visit or urgent care setting if otherwise covered under the CONTRACT. 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 the prescription drug benefits of the CONTRACT.

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) and (d)(1)

The Department of Employee Trust Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact ETF's Compliance Officer, who serves as ETF's Civil Rights Coordinator.

If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Officer, Department of Employee Trust Funds, 801 West Badger Road, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 1-800-947-3529; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 1-800-833-7813).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020（TTY：1-800-947-3529）

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 1-800-947-3529).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 1-800-947-3529)

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 1-800-947-3529)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 1-800-947-3529).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 1-800-947-3529).

Laotian/Lao: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 1-800-947-3529).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-533-5020 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-533-5020 (TTY: 1-800-947-3529).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 1-800-947-3529).