Medicare Plus

Health Care Benefit Plan
Wisconsin Group Insurance Board

Department of Employee Trust Funds
P.O. Box 7931 • 801 W. Badger Rd., Madison, WI 53707-7931

ET-4113 (REV 1/2015)

GENERAL INFORMATION ABOUT YOUR PLAN

Your comprehensive health care benefit plan is provided by The State of Wisconsin for its EMPLOYEES and ANNUITANTS under the terms and conditions of the Group Master Plan Document on file with The State of Wisconsin.

All medical expenses covered under your health care benefit 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.

This booklet 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. This booklet explains how the Plan works: what it pays for, what is not covered, how to submit expenses and claim benefits. Every medical cost situation cannot be specifically described in this material.

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.

This past year there has been some confusion about preauthorization and pre-certification. The following information is intended to help you better understand these topics. Medicare Plus does not require preauthorization or pre-certification.

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. More information appears in this booklet on page 42.

Pre-certification – Pre-certification, that is certification of inpatient hospitalizations, is managed by WPS Medical Management and does not appear in your benefit booklet as it is not required.

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.

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
1751 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 Westwood Center Blvd., Suite 200
Wausau, Wisconsin 54401

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COMPARISON OF OTHER STATE PLANS TO MEDICARE PLUS

The change from the Standard/SMP to the Medicare Plus mainly involves a reduction in premium because Medicare will be paying a substantial portion of the health care costs. All plans are excellent, but there will be some additions and some loss in BENEFITS. The following are general examples of those differences.

Item	Standard/SMP	Medicare Plus
Deductible	**Standard:** $200 per person, not to exceed $400 per family in network; $500 per person, not to exceed $1,000 per family out of network **SMP:** No Deductible	No Deductible
Benefits	**Standard:** Benefits are paid at either 90% or 70% depending on choice of in or out of network provider **SMP:** Most benefits paid at 90%	Plan pays Medicare Part A and B deductibles and other covered services
Treatment of Alcoholism, Drug Abuse and Nervous and Mental Disorders (other than inpatient)	**Standard:** Benefits are paid at either 90% or 70% depending on choice of in or out of network provider **SMP:** Benefits paid at 90%	Plan pays Medicare Part A and B deductibles and other covered services

OUTLINE OF COVERAGE MEDICARE PLUS

Services and Supplies	Medicare Pays per Benefit Period	Medicare Plus Pays
Hospital Semiprivate room and board and miscellaneous hospital services and supplies such as drugs, x-rays, lab tests and operating room	First 60 days, all but $1,260* 61st to 90th day, all but $315* a day 91st to 150th day, all but $630* a day (Lifetime Reserve) If lifetime reserve days are exhausted, $0	Initial $1,260* deductible $315* a day $630* 100% from the 91st to 120th day of confinement
Licensed Skilled Nursing Facility** Medicare covered services in a Medicare Approved Facility**	Requires a 3-day period of hospital stay First 20 days, 100% of costs 21st - 100th days, all but $157.50 a day Beyond 100 days, $0	Requires a 3-day period of hospital stay Not Applicable $157.50* a day All covered services up to a maximum of 120 days per BENEFIT PERIOD. Custodial care is not covered.
Licensed Skilled Nursing Facility** (**Non**-Medicare Approved Facility) If admitted within 24 hours following a hospital stay	Covers only the same type of expenses normally covered by Medicare in a Medicare Approved Facility $0	Covers only the same type of expenses normally covered by Medicare in a Medicare Approved Facility Maximum daily rate for up to 30 days per confinement

* Federal Medicare deductibles are adjusted annually. Amounts shown above are for 2015. Medicare Plus benefits are also adjusted annually to pay these deductibles.

** Custodial care as defined is not covered.

Services and Supplies	Medicare Pays per Benefit Period	Medicare Plus Pays
Home Health Care** Under an approved plan of care, part-time services of an RN, LPN or home health aide; physical, respiratory, speech or occupational therapy; medical supplies, drugs, lab services and nutritional counseling	100% of charges for visits considered medically necessary by Medicare. Generally 5 visits per week for 2 to 3 weeks; or 4 or fewer visits per week as long as required	Up to 365 visits per year
Hospice Care Medicare certified program of terminal illness care for pain relief and symptom management. Includes: nursing care; physician services; physical, occupational and speech therapy; social worker services; home health aids; homeworker services; medical supplies. First 180 days and any Medicare approved extension	All covered services	Coinsurance or copayments for all MEDICARE Part A eligible expenses
Hospice Facility	All but very limited coinsurance for inpatient respite care	Medicare copayment/coinsurance up to the equivalent charges of a Skilled Nursing Facility
Miscellaneous Services Physical, speech and occupational therapy; ambulance; prosthetic devices; durable medical equipment	After annual $147* Medicare deductible, 80% of allowable charges	Initial $147* deductible and 20% of Medicare approved expenses

* Federal Medicare deductibles are adjusted annually. Amounts shown above are for 2015. Medicare Plus benefits are also adjusted annually to pay these deductibles.
** Custodial care as defined is not covered.

Services and Supplies	Medicare Pays per Benefit Period	Medicare Plus Pays
Physician's Services Includes medical care, surgery, home and office calls, dental surgeons, anesthesiologists, etc.	After annual $147* Medicare deductible, 80% of allowable charges	Initial $147* deductible and 20% of Medicare approved expenses
Drugs and Biologicals (non-hospitalization) Immunosuppressive drugs during the first year following a covered transplant Self-administered drugs prescribed by a physician	After annual $147* Medicare deductible, 80% of allowable charges Not Covered	Initial $147 deductible and 20% of Medicare approved expenses Refer to Pharmacy Benefit Manager portion of booklet for pharmacy benefits
Outpatient Hospital Services In an emergency room or outpatient clinic, diagnostic lab and x-rays; medical supplies such as casts, splints, and drugs which cannot be self-administered	After the annual $147* Medicare deductible, 80% of allowable charges	Initial $147* deductible and 20% of Medicare approved expenses
Psychiatric Treatment Other than hospital inpatient	After the annual $147* Medicare deductible, 50% of the allowable charges	Initial $147* deductible and the amount, which combined with the Medicare benefit, equals 90% of the reasonable charges
Private Duty Nursing While hospitalized and provided by an RN or LPN	$0	$0
Blood	After annual $147* Medicare deductible, 80% of costs except non-replacement fees (blood DEDUCTIBLE) 1st 3 pints in each benefit period	Initial $147* deductible and 20% of Medicare approved expenses

* Federal Medicare deductibles are adjusted annually. Amounts shown above are for 2015. Medicare Plus benefits are also adjusted annually to pay these deductibles.
** Custodial care as defined is not covered.

DEFINITIONS

The following terms, when used and capitalized in this HEALTH BENEFIT PLAN, are defined as follows:

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; or (3) is receiving a long-term disability benefit under Wis. Adm. Code § 50.40; or (d) is receiving a disability benefit under Wis. Stats. § 40.65.

ASSIGNMENT means that a PARTICIPANT'S PHYSICIAN or HEALTH CARE PROVIDER agrees (or is required by law) to accept the MEDICARE-approved amount as full payment for covered HEALTH CARE SERVICES.

BALANCE BILL means seeking: to bill, charge, or collect a deposit, remuneration or compensation from; to file or threaten to file with a credit reporting agency; or to have any recourse against you or any person acting on your behalf for health care costs for which you are not liable. The prohibition on recovery does not affect your liability for any deductibles, coinsurance or copayments, or for premiums owed under the PLAN.

BENEFIT PERIOD means the total duration of all successive CONFINEMENTS that are separated from each other by less than 60 days.

BENEFITS mean payments for HOSPITAL SERVICES, LICENSED SKILLED NURSING FACILITY SERVICES, HOSPICE CARE SERVICES, PROFESSIONAL and OTHER SERVICES.

BOARD means the Group Insurance Board.

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.

CHARGES: The reasonable CHARGES for items or services set by MEDICARE. WPS treats CHARGES for stays in a HOSPITAL or LICENSED SKILLED NURSING FACILITY as incurred on the date of admission. WPS treats all other CHARGES as incurred on the date the PARTICIPANT gets the service or item. BENEFITS are payable only up to the reasonable charge set by MEDICARE, except as stated in subsection B. below. No agreement between the PARTICIPANT (or someone acting for the PARTICIPANT) and any other person, group, or provider of services will cause the PLAN to pay more,

CONFINEMENT means the period starting with a PARTICIPANT'S admission on an INPATIENT basis (more than 24 hours) to a GENERAL HOSPITAL, SPECIALTY HOSPITAL, LICENSED SKILLED NURSING FACILITY or EXTENDED CARE FACILITY for TREATMENT of an ILLNESS or INJURY. CONFINEMENT ends with the PARTICIPANT'S discharge from the same HOSPITAL or other facility. If a PARTICIPANT is transferred to another HOSPITAL or other facility for continued TREATMENT of the same or related ILLNESS or INJURY, it's still just one confinement.

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

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

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 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 which can withstand repeated use and is, as determined by WPS:

1. Primarily used to serve a medical purpose with respect to an ILLNESS or INJURY;

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

3. Appropriate for use in the PARTICIPANT'S home; and

4. Prescribed by a PHYSICIAN.

All requirements of this definition must be satisfied before an item can be considered to be DURABLE MEDICAL EQUIPMENT.

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

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.

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 means, as determined by WPS' Corporate Medical Director, the use of any HEALTH CARE SERVICE for a PARTICIPANT'S ILLNESS or INJURY, that, at the time it is used, meets one or more of the following:

1. Requires approval that has not been granted by the appropriate federal or other governmental agency such as, but not limited to, the federal Food and Drug Administration (FDA); or

2. Isn't yet recognized as acceptable medical practice throughout the United States to treat that ILLNESS or INJURY.

3. Is the subject of either: (a) a written investigational or research protocol; or (b) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (c) an ongoing phase I, II or III clinical trial, except as required by law; or (d) an ongoing review by an Institutional Review Board (IRB); or

4. Doesn't have either: (a) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (b) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning such treatment, service or supply and reflecting its recognition and reproducibility by non-affiliated sources we determine to be authoritative.

The criteria that WPS uses for determining whether a HEALTH CARE SERVICE is considered to be EXPERIMENTAL/INVESTIGATIVE and, therefore, not covered for a particular ILLNESS or INJURY include, but are not limited to:

1. Whether the HEALTH CARE SERVICE is commonly performed or used on a widespread geographic basis;

2. Whether the HEALTH CARE SERVICE 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 HEALTH CARE SERVICE;

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

5. Whether the HEALTH CARE SERVICE is MEDICALLY NECESSARY;

6. Whether the HEALTH CARE SERVICE is recognized as not EXPERIMENTAL or INVESTIGATIVE by MEDICARE, Medicaid and other third party payers (including insurers and self-funded plans).

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

FAMILY COVERAGE means coverage applies to a SUBSCRIBER, his/her spouse 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 cannot 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.

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.

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

HEALTH CARE PROVIDER means any person, institution or other entity licensed by the state in which he/she is located to provide HEALTH CARE SERVICES covered by the PLAN to a PARTICIPANT within the lawful scope of his/her license.

HEALTH CARE SERVICES means TREATMENT, services, procedures, drugs or medicines, devices or supplies directly provided to a PARTICIPANT and covered under the PLAN, except to the extent that such TREATMENT, services, procedures, drugs or medicines, devices or supplies are limited or excluded under the PLAN.

HOME CARE means HEALTH CARE SERVICES provided to a PARTICIPANT in his/her home under a written home care plan. The attending PHYSICIAN must set up the home care plan. Such plan must be approved in writing by that PHYSICIAN. He/she must review is at least every two months; but this can be less frequent if he/she decides longer intervals are enough and WPS agrees.

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

HOSPITAL means a GENERAL HOSPITAL and a SPECIALTY HOSPITAL.

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.

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

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

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

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

LICENSED SKILLED NURSING FACILITY means a SKILLED NURSING FACILITY licensed as a SKILLED NURSING FACILITY by the state in which it is located. The facility must be staffed, maintained and equipped to provide these skilled nursing services continuously: observation and assessment; care; restorative and activity programs. These must be under professional direction and medical supervision as needed.

LIFETIME RESERVE DAYS mean additional days that MEDICARE will pay for when the PARTICIPANT is in a hospital for more than 90 days. The PARTICIPANT has a total of 60 reserve days that can be used during his/her lifetime. For each lifetime reserve day, MEDICARE pays all covered costs except for a daily coinsurance.

LIMITING CHARGE means the amount above the MEDICARE-approved amount billed by a NON-PARTICIPATING PROVIDER and allowed by MEDICARE.

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

MEDICALLY NECESSARY means a HEALTH CARE SERVICE directly provided to a PARTICIPANT by a HOSPITAL, PHYSICIAN or other HEALTH CARE PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by WPS:

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.

The fact that a PHYSICIAN or OTHER HEALTH CARE PROVIDER has prescribed, ordered, or recommended or approved a HEALTH CARE SERVICE does not in itself make it MEDICALLY NECESSARY or otherwise eligible for payment.

MEDICAL SERVICES means PROFESSIONAL SERVICES recognized by doctors of medicine in the TREATMENT of ILLNESS or INJURY. Not included are: MATERNITY SERVICES; surgery; anesthesiology; pathology; and radiology.

MEDICAL SUPPLIES means items that are, as determined by WPS:

1. 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 items which can safely be provided to a PARTICIPANT and accomplish the desired end result in the most economical manner; and

4. Prescribed by a PHYSICIAN. The item's primary function must not be for comfort or convenience.

MEDICARE means benefits available under Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE ELIGIBLE EXPENSES means health care expenses that are covered by MEDICARE Parts A and B, recognized as MEDICALLY NECESSARY and reasonable by MEDICARE, and that may or may not be fully reimbursed by MEDICARE.

NERVOUS OR MENTAL DISORDER means any condition classified as a neurosis, psychoneurosis, psychopathy or psychosis.

NON-AFFILIATED PROVIDER means (1) a PHYSICIAN or HEALTH CARE PROVIDER that has decided not to provide SERVICES through MEDICARE and MEDICARE will not cover those SERVICES; or (2) a licensed HEALTH CARE PROVIDER who is not allowed to bill MEDICARE for SERVICES.

NON-PARTICIPATING PROVIDER means that a PHYSICIAN or HEALTH CARE PROVIDER has not signed an agreement to accept assignment for all MEDICARE covered SERVICES, but they can still choose to accept assignment for individual SERVICES.

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

OTHER SERVICES means those SERVICES, if any, specified in this CONTRACT other than HOSPITAL SERVICES and PROFESSIONAL SERVICES.

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

PARTICIPANT means a SUBSCRIBER, or any of his/her DEPENDENTS, eligible for MEDICARE for whom proper application for MEDICARE PLUS coverage has been made and for whom the appropriate PREMIUM has been paid.

PARTICIPATING PROVIDER means that a PHYSICIAN or HEALTH CARE PROVIDER has signed an agreement to accept assignment for all MEDICARE covered SERVICES.

PHYSICIAN means a person who received a degree in medicine from an accredited college or university and is a medical doctor or surgeon licensed by the state in which he/she is located and provides HEALTH CARE SERVICES while he/she is acting within the lawful scope of his/her license. A PHYSICIAN is limited to the following:

1. Doctor of Medicine (M.D.);

2. Doctor of Osteopathy (O.S.);

3. Doctor of Dental Surgery (D.D.S.);

4. Doctor of Dental Medicine (D.D.M.);

5. Doctor of Surgical Chiropody (D.S.C.);

6. Doctor of Podiatric Medicine (D.P.M.);

7. Doctor of Optometry (O.D.);

8. Doctor of Chiropractic (D. C.).

When required by law to cover the HEALTH CARE SERVICES of any other licensed medical professional under this CONTRACT, a PHYSICIAN also includes such other licensed medical professional who: (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 which WPS determines is a covered expense under the PLAN.

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.

REASONABLE CHARGES means an amount for a HEALTH CARE SERVICE that is reasonable, as determined by WPS. WPS takes into consideration, among other factors (including national sources) determined by WPS: (1) amounts charged by HEALTH CARE PROVIDERS for similar HEALTH CARE SERVICES when provided in the same geographical area; (2) WPS' methodology guidelines; (3) pricing guidelines of any third party responsible pricing a claim; and (4) the negotiated rate determined by WPS in accordance with the applicable contract between WPS and a HEALTH CARE PROVIDER. As used herein, 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. Also, the amount WPS determines as reasonable may be less than the amount billed. This definition applies only to paragraph 6.

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 (intrarterial) injections or any drug administered through infusion.

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

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

SKILLED NURSING CARE means HEALTH CARE SERVICES furnished on a PHYSICIAN'S orders which requires the skills of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the direct supervision of such professional personnel.

SKILLED NURSING FACILITY means an institution (or part of one) that: (1) is operated pursuant to law; (2) primarily engages in providing, in addition to room and board accommodations, SKILLED NURSING CARE under the supervision of a duly licensed PHYSICIAN; (c) provides continuous twenty-four (24) hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and (d) maintains a daily medical record of each patient. Except incidentally, it isn't a home or facility used primarily for rest, drug addicts, alcoholics, treatment of mental diseases or disorders, or custodial or educational care.

SMP means State Maintenance Plan.

STANDARD PLAN means this CONTRACT excluding SMP, 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 supplies directly provided to a PARTICIPANT by a HEALTH CARE PROVIDER, as determined by WPS.

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

TRANSITIONAL TREATMENT ARRANGEMENTS means SERVICES more intensive than OUTPATIENT visits but less intensive than an overnight stay in the HOSPITAL. Most often, transitional care will be rendered in a day treatment program that provides successive hours of therapy. We cover transitional SERVICES in the following settings:

1. A certified Adult Mental Health Day Treatment Program as defined in HFS 61.75 Wis. Adm. Code.

2. A certified Child/Adolescent Mental Health Day Treatment Program as defined as HFS 40.04 Wis. Adm. Code.

3. A certified AODA Day Treatment Program as defined in HFS 75.12(1) and (2) Wis. Adm. Code.

4. A certified Community Support Program as defined in HFS 63.03 Wis. Adm. Code.

5. A certified Residential AODA Treatment Program as defined in HFS 75.14(1) and (2) Wis. Adm. Code.

6. Intensive outpatient programs for the TREATMENT of substance abuse disorders provided in accordance with the criteria established by the American Society of Addiction Medicine.

7. SERVICES provided by a program certified under HFS 34.03 and provided in accordance with subchapter III HFS34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other providers for stabilization.

8. Out of state SERVICES and programs that are substantially similar to 1., 2., 3., 4. and 5. if the provider is in compliance with similar requirements of the state in which the health care provider is located.

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

TREATMENT means management and care directly provided to a PARTICIPANT by a PHYSICIAN or other HEALTH CARE PROVIDER for the diagnosis, remedy, therapy, combating, or the combination thereof, of an ILLNESS or INJURY, as determined by WPS.

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

MEDICARE PLUS PLAN

The Medicare Plus plan is designed to supplement BENEFITS available under MEDICARE. It is designed for ANNUITANTS and their DEPENDENTS and is not available to active EMPLOYEES or their DEPENDENTS.

All persons must enroll for MEDICARE - both Part A HOSPITAL and Part B Medical when first eligible. Otherwise, your state group coverage is subject to cancellation without reinstatement. (This provision is delayed only for active EMPLOYEES, their spouses and their dependent children, until the EMPLOYEE terminates State employment.)

MEDICARE becomes available at age 65, or after Social Security disability benefits have been received for 24 months, or for those who have chronic kidney disease.

Your Medicare Plus coverage will terminate under the following conditions:

1. If you decide to cancel your Medicare Plus coverage while still an ANNUITANT. You must submit a written signed request to the DEPARTMENT.

2. If your Medicare Plus coverage terminates for any reason other than voluntary cancellation, BENEFITS will continue for any ILLNESS or INJURY previously covered by the CONTRACT. This extension will be effective until the end of the BENEFIT PERIOD.

3. If your eligibility for inclusion under the State of Wisconsin's group health coverage plan ceases, your Medicare Plus group coverage will be null and void on the last day of the same month. You may then continue coverage by making payment directly to WPS for the applicable Medicare Supplement policy then being issued. Continuous coverage depends on the fulfillment of the direct pay contract requirements, conditions and premium rates.

4. Failure to pay PREMIUMS timely when billed will result in cancellation of coverage with no opportunity to reinstate.

This booklet describes the benefit provisions. Additional information may be obtained from:

1. State EMPLOYEES Standard Plan booklet - "Standard Plan - Health Care Benefit Plan" published for the DEPARTMENT by WPS.

2. "Your Medicare Handbook" published by the Social Security Administration; and

3. "It's Your Choice: Reference Guide" and "It's Your Choice: Decision Guide" brochures published every October by the DEPARTMENT.

BENEFITS AVAILABLE

Except as excluded in this section and sections "EXCLUSIONS" and "GENERAL CONDITIONS", BENEFITS are payable for CHARGES for the following SERVICES and supplies on or after the EFFECTIVE DATE according to the terms, conditions and provisions of this CONTRACT, if those SERVICES and supplies are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and TREATMENT of the PARTICIPANT, as determined by WPS.

When SERVICES are provided by a NON-PARTICIPATING PROVIDER, BENEFITS are payable for amounts in excess of the MEDICARE-approved CHARGE up to the lesser of the actual amount charged by the NON-PARTICIPATING PROVIDER and the LIMITING CHARGE.

The BENEFITS of this section of the PLAN will automatically change to coincide with any changes in applicable MEDICARE deductible amounts and coinsurance percentage factors.

HOSPITAL INPATIENT BENEFITS

1. BENEFITS are payable for the MEDICARE Part A deductible during the first 60 days of CONFINEMENT.

2. BENEFITS are payable for the MEDICARE Part A HOSPITAL daily coinsurance from the 61st to the 90th day of a PARTICIPANT'S CONFINEMENT.

3. After a PARTICIPANT has been in a HOSPITAL for 90 days, Medicare pays an extra 60 reserve days during the PARTICIPANT'S lifetime. BENEFITS are payable for the MEDICARE Part A HOSPITAL coinsurance for each reserve day used by the PARTICIPANT.

If the PARTICIPANT has exhausted the lifetime reserve days during a previous BENEFIT PERIOD, BENEFITS will continue to be payable for an additional 30 days of CONFINEMENT beginning on the 91st day of CONFINEMENT. The provider shall accept our payment as payment in full and may not balance bill you.

4. After MEDICARE pays its 190-day lifetime hospital INPATIENT psychiatric care BENEFITS, the PLAN will pay the MEDICARE Part A ELIGIBLE EXPENSES for INPATIENT psychiatric HOSPITAL care for each day a PARTICIPANT is confined for psychiatric care beyond the MEDICARE lifetime limit but not to exceed a lifetime limit of 175 days CONFINEMENT under the PLAN. BENEFITS will not exceed a total of 365 days for your lifetime.

5. BENEFITS are payable for the MEDICARE Part A ELIGIBLE EXPENSES for blood to the extent not covered by MEDICARE.

Alcoholism, Drug Abuse and NERVOUS and MENTAL DISORDERS

1. INPATIENT HOSPITAL SERVICES.

This paragraph applies to those PARTICIPANTS admitted as resident patients for TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable at 100% of the CHARGES after MEDICARE'S payment each CALENDAR YEAR.

HOSPITAL SERVICES are not to exceed 365 days of CONFINEMENT throughout a PARTICIPANT'S lifetime while the PARTICIPANT is covered under the CONTRACT following the EFFECTIVE DATE.

2. OUTPATIENT HOSPITAL SERVICES.

TREATMENT of alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS for a PARTICIPANT other than as an INPATIENT is limited to the initial Part B deductible and the amount which combined with the MEDICARE BENEFIT equals 90% in CHARGES during any CALENDAR YEAR.

Such TREATMENT SERVICES must be provided by:

a. a program in an outpatient treatment facility, if both the program and facility are approved by the Department and established and maintained according to rules promulgated under Section 51.42 (7)(b), Wisconsin Statutes, as amended;

b. a licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office;

c. a psychologist licensed or certified by the state in which he/she is located; or

d. a clinical social worker, marriage and family therapist or professional counselor licensed or certified by the state in which he/she is located to provide nonresidential services or the TREATMENT of NERVOUS OR MENTAL DISORDERS, alcoholism or drug abuse.

3. TRANSITIONAL TREATMENT ARRANGEMENTS.

Transitional TREATMENT is limited to the initial Part B deductible and the amount which combined with the MEDICARE BENEFIT equals 90% in CHARGES during any CALENDAR YEAR.

The criteria that WPS uses to evaluate a Transitional TREATMENT program or SERVICE to determine whether it is covered under the CONTRACT include, but are not limited to:

a. the program is certified by the Department of Health and Family SERVICES;

b. the program meets the accreditation standards of the Joint commission on Accreditation of Healthcare Organizations;

c. the specific diagnosis is consistent with the symptoms;

d. the TREATMENT is standard medical practice and appropriate for the specific diagnosis;

e. the multidisciplinary team running the program is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider's program is located or the SERVICE provided.

f. see the definition of "MEDICALLY NECESSARY" in the definitions.

WPS will need the following information from the HEALTH CARE PROVIDER to help us determine the medical necessity of such program SERVICE:

a. a summary of the development of the PARTICIPANT'S ILLNESS and previous TREATMENT.

b. a well defined TREATMENT plan listing TREATMENT objectives, goals and duration of the care provided under the TRANSITIONAL TREATMENT ARRANGEMENT program.

c. a list of credentials of the staff who participated in the TRANSITIONAL TREATMENT ARRANGEMENT program or SERVICE, unless the program or SERVICE is certified by the Department of Health and Family Services.

SERVICES in a LICENSED SKILLED NURSING FACILITY

1. CONFINEMENTS Covered by MEDICARE.

For CONFINEMENT in a LICENSED SKILLED NURSING FACILITY certified by and participating in MEDICARE, while the CONFINEMENT is covered by MEDICARE, BENEFITS are payable for such a CONFINMENT, provided: (a) a PARTICIPANT receives care in a MEDICARE approved LICENSED SKILLED NURSING FACILITY and remains under continuous active medical supervision; and (b) the PARTICIPANT was a HOSPITAL INPATIENT for at least three days prior to CONFINEMENT in a LICENSED SKILLED NURSING FACILITY. BENEFITS are payable for up to a maximum of 120 days per BENEFIT PERIOD beginning on the first day of admission to the LICENSED SKILLED NURSING FACILITY.

2. CONFINEMENTS Not Participating in MEDICARE or Not Covered by MEDICARE.

For CONFINEMENT in a LICENSED SKILLED NURSING FACILITY not participating in MEDICARE, or when the CONFINEMENT is not covered by MEDICARE, BENEFITS are payable provided the PARTICIPANT is transferred within 24 hours of release from a HOSPITAL. BENEFITS are payable up to the maximum daily rate established for SKILLED NURSING CARE in that facility by the Department of Health and Family Services for purposes of reimbursement under the Medical Assistance Program under Wis. Stats. § 49.45 to 49.47. BENEFITS are payable for such care at that facility up to 30 days per CONFINEMENT. BENEFITS are payable only if the attending PHYSICIAN certifies that the SKILLED NURSING CARE is MEDICALLY NECESSARY. The PHYSICIAN must recertify this every seven days. BENEFITS are not payable for essentially domiciliary or CUSTODIAL CARE, or care which is available to the PARTICIPANT without CHARGE or under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes).

HOSIPICE CARE

The PLAN will pay a PARTICIPANT'S coinsurance or co-payments for all MEDICARE PART A ELIGIBLE EXPENSES for HOSPICE CARE and respite care. HOSPICE CARE is available as long as the PARTICIPANT'S PHYSICIAN certifies that he/she is terminally ill and his/her care is eligible for payment under Part A of MEDICARE.

Professional and OTHER SERVICES

The PLAN will pay the MEDICARE Part B deductible and all MEDICARE Part B ELIGIBLE EXPENSES, to the extent not paid by MEDICARE, or in the case of HOSPITAL outpatient

department SERVICES paid under a prospective payment system, the COPAYMENT amount, for the following SERVICES.

1. Cataract lenses following cataract surgery and one pair of eyeglasses with standard frames (or one set of contract lenses) after cataract surgery that implants an intraocular lens.

2. Chemotherapy in a PHYSICIAN'S office, freestanding clinic or HOSPITAL outpatient setting.

3. Prescription drugs covered by MEDICARE such as injections that can't be self-administered that a PARTICIPANT receives in a PHYSICIAN'S office, certain oral cancer drugs, drugs used with some types of DURABLE MEDICAL EQUIPMENT, and under very limited circumstances, certain drugs a PARTICIPANT receives in a HOSPITAL OUTPATIENT setting.

4. Physical therapy, speech-language pathology services and occupational therapy when recommended by a PHYSICIAN.

5. Oxygen and rental of equipment and supplies for its administration.

6. Professional licensed ambulance SERVICE necessary to transport a PARTICIPANT to or from a HOSPITAL or LICENSED SKILLED NURSING FACILITY. 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.

7. MEDICAL SUPPLIES prescribed by a PHYSICIAN.

8. Rental of or purchase of DURABLE MEDICAL EQUIPMENT such as, but not limited to: wheelchairs, walkers and hospital type beds.

9. OUTPATIENT cardiac rehabilitation SERVICES.

10. Facility fees for approved surgical procedures in an ambulatory surgical center.

11. Blood processing and handling services for every unit of blood a PARTICIPANT receives.

12. Chiropractic services limited to those services to help correct a sublaxation using manipulation of the spine. BENEFITS are not payable for any other SERVICES or tests ordered by a chiropractor (including x-rays or massage therapy).

13. X-rays, MRIs, CT scans, EKGs, and other diagnostic tests, other than laboratory tests.

14. Diabetes supplies and self-management training.

15. PHYSICIAN SERVICES that are MEDICALLY NECESSARY or provided in connection with preventive SERVICES covered by MEDICARE. BENEFITS are also payable for SERVICES provided by HEALTH CARE PROVIDERS, such as physician assistants, nurse practitioners, social workers, and psychologists.

16. Foot exams and treatment if a PARTICIPANT has diabetes-related nerve damage and/or meets certain conditions determined by MEDICARE.

17. Kidney dialysis SERVICES and supplies. This includes dialysis medications, laboratory tests, home dialysis training and related equipment and supplies. In addition, BENEFITS are also payable for CHARGES for kidney disease education services prescribed by a PHYSICIAN.

18. Outpatient mental health care SERVICES. Coverage includes SERVICES generally provided in an OUTPATIENT setting, including visits with a psychiatrist or other PHYSICIAN, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist or clinical social worker.

19. Outpatient HOSPITAL SERVICES, OUTPATIENT medical and surgical SERVICES and supplies.

20. Prosthetic and orthotic items including arm, leg, back and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part of function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a PHYSICIAN or other HEALTH CARE PROVIDER.

21. Pulmonary rehabilitation programs if a PARTICIPANT has moderate to severe chronic obstructive pulmonary disease prescribed by a PHYSICIAN.

22. SERVICES for treatment of a surgical or surgically-treated wound.

23. Tobacco smoking cessation counseling if a PARTICIPANT is diagnosed with an ILLNESS caused or complicated by tobacco use or takes a medicine that is affected by tobacco.

24. Physician SERVICES for heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a MEDICARE-certified facility. Also covered are immunosuppressive drugs if the transplant was eligible for MEDICARE payment, or an employer or union group health plan was required to pay before MEDICARE paid for the transplant.

25. Glaucoma tests once every 12 months for PARTICIPANTS at high risk for glaucoma.

Additional SERVICES

1. Foreign Travel.

BENEFITS are payable at 100% of the REASONABLE CHARGES for MEDICALLY NECESSARY HEALTH CARE SERVICES received by a PARTICIPANT in a foreign country.

2. Immunizations.

BENEFITS are payable at 100% of the REASONABLE CHARGES for immunizations not covered by MEDICARE.

3. Chiropractic SERVICES.

BENEFITS are payable at 100% of the REASONABLE CHARGES for chiropractic SERVICES provided by a chiropractor within the scope of his/her license and not covered by MEDICARE per Wis. Stat. 632.875.

4. HOME CARE.

BENEFITS are payable at 100% of the REASONABLE CHARGES for HOME CARE SERVICES described below:

a. Covered SERVICES. This paragraph only if CHARGES for HOME CARE SERVICES are not covered elsewhere under this CONTRACT. A state licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the SERVICES. A PARTICIPANT should make sure the agency meets this requirement before SERVICES are provided. BENEFITS are payable for CHARGES for the following SERVICES when MEDICALLY NECESSARY for treatment. MEDICARE benefits will not be duplicated.

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

(2) part time or intermittent home health aide SERVICES when MEDICALLY NECESSARY as part of the HOME CARE plan. The SERVICES must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;

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

(4) MEDICAL SUPPLIES, prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN required to be administered by a professional provider; laboratory SERVICES by or on behalf of a

HOSPITAL, if needed under the HOME CARE plan. These items are covered to the extent they would be if the PARTICIPANT had been hospitalized;

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

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

b. Limitations. The following limits apply to HOME CARE SERVICES:

(1) HOME CARE isn't covered unless the PARTICIPANT'S attending PHYSICIAN certifies that: (a) hospitalization or CONFINEMENT in a LICENSED SKILLED NURSING FACILITY would be needed if the PARTICIPANT didn't have HOME CARE; and (b) members of the PARTICIPANT'S IMMEDIATE FAMILY or others living with the PARTICIPANT couldn't give the PARTICIPANT the care and treatment he/she needs without undue hardship;

(2) if the PARTICIPANT was hospitalized just before HOME CARE started, the PARTICIPANT'S PHYSICIAN during his/her HOSPITAL stay must also approve the HOME CARE plan;

(3) BENEFITS are payable for CHARGES for up to 365 HOME CARE visits in any 12 month period per PARTICIPANT. Each visit by a person providing SERVICES under a HOME CARE plan, evaluating the PARTICIPANT'S need or developing a plan counts as one visit. Each period of up to four straight hours in a 24-hour period of home health aide SERVICE counts as one HOME CARE visit.

(4) if HOME CARE is covered under two or more health insurance CONTRACTS or plans, coverage is payable under only one of them. The same is true if the PARTICIPANT has HOME CARE coverage under this CONTRACT and another source;

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

5. Equipment and Supplies for Treatment of Diabetes.

BENEFITS are payable at 100% of the REASONABLE CHARGES incurred for the installation and use of an insulin infusion pump, all other equipment and supplies, (except insulin and medical supplies for injection of insulin which

include syringes, needles, alcohol swabs, and gauze) used in the treatment of diabetes, and charges for diabetic self-management education programs. This benefit is limited to the purchase of one pump per calendar year. You must use the pump for at least 30 days before the pump is purchased. Medicare benefits won't be duplicated.

6. BENEFITS for Kidney Disease.

BENEFITS are payable for REASONABLE CHARGES for inpatient, outpatient and home treatment of kidney disease, if not covered elsewhere under the PLAN. These services must be necessary for a PARTICIPANT'S diagnosis and treatment. This includes dialysis treatment and kidney transplantation expenses of both donor and recipient. There's a maximum of $30,000 per year for these BENEFITS. The PLAN will not pay any BENEFITS for any CHARGES paid for, or covered by, MEDICARE.

7. Breast Reconstruction.

BENEFITS are payable for REASONABLE CHARGES for breast reconstruction of the affected tissue incident to a mastectomy.

8. Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care.

BENEFITS are payable for REASONABLE CHARGES for HOSPITAL or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided in a hospital or ambulatory surgery center, if any of the following applies:

(a) the PARTICIPANT is a child under the age of 5;

(b) the PARTICIPANT has a chronic disability that meets all of the conditions under s. 230.04(9r) (a) 2. a., b. and c., Wisconsin Statutes; or

(c) the PARTICIPANT has a medical condition that requires hospitalization or general anesthesia for dental care.

9. HEALTH CARE SERVICES Provided by a NON-AFFILIATED PROVIDER.

If a PARTICIPANT receives SERVICES from a NON-AFFLIATED PROVIDER, BENEFITS will be payable for REASONABLE CHARGES for those SERVICES provided the SERVICES are covered under this section.

EXCLUSIONS

The following SERVICES are excluded from BENEFITS, except as otherwise specifically provided:

1. HEALTH CARE SERVICES MEDICARE does not cover, unless the PLAN specifically provides for them.

2. HEALTH CARE SERVICES which neither a PARTICIPANT nor a party on the PARTICIPANT'S behalf has a legal obligation to pay in the absence of insurance.

3. HEALTH CARE SERVICES to the extent that they are paid for by MEDICARE, or would have been paid for by MEDICARE if a PARTICIPANT is enrolled in MEDICARE Parts A and B; HEALTH CARE SERVICES to the extent that they are paid for by another government entity or program, directly or indirectly.

4. Personal comfort items. Examples include: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature.

5. CUSTODIAL CARE, including maintenance care and supportive care.

6. Cosmetic surgery.

7. HEALTH CARE SERVICES received by a PARTICIPANT before his/her coverage becomes effective or after coverage ends.

8. HEALTH CARE SERVICES that are deemed unreasonable and unnecessary by MEDICARE. This includes, but is not limited to, the following: drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA; and services including drugs or devices, not considered safe and effective because they are experimental or investigational except for the HIV drugs as described in Section 632.895(9) Wis. Stat. as amended.

9. HEALTH CARE SERVICES received outside the United States, except as specifically stated in paragraph 6. a. of subsection B.

10. Amounts billed by a PHYSICIAN exceeding the MEDICARE approved amount, except as specifically stated in subsection B.

11. HEALTH CARE SERVICES which aren't MEDICALLY NECESSARY as determined by WPS, except for such HEALTH CARE SERVICES that MEDICARE covers.

12. Routine physical exams and any related diagnostic X-ray and laboratory tests covered by MEDICARE.

13. Private duty nursing.

14. Routine dental care.

15. Hearing aids; exams for fitting of hearing aids.

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 7. 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.

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) pre-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.

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" link found on the left hand side of the page, then follow these instructions:

- **a.** Click on the "PAR Directory" link.
- **b.** Select your network by clicking under "Search for a PAR Provider"
- **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 "Search" button.
- **d.** Read the disclaimer, then click "Continue" 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.

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 a sample EOB form and corresponding explanation of the most pertinent information that appears on the following pages.

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 Name of Service Servicing Provider	Service Dates 10 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) SCHEDULE OF BENEFITS - MEDICARE PLUS

The following description of the pharmacy benefit program is an excerpt from parts of Uniform Benefits that apply to your prescription drug coverage. This is printed here for your convenience. A complete description of benefits, exclusions and limitations can be found in your "It's Your Choice: Reference Guide" book in the Uniform Benefits section I Schedule of Benefits and III Benefits and Services D. Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM). Exclusions and limitations are found under IV #11. 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 - $15.00. Level 2 consists of formulary brand name and certain higher cost generic drugs.

c. Level 3 - copayment for non-formulary prescription drugs - $35.00.

2. Annual Out-of-Pocket Maximum (The Amount You Pay for Your Level 1 and Level 2 Prescription Drugs and Insulin):

$410.00 per individual $820.00 per family for all participants

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

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.