Wisconsin Public Employers Group Health Insurance Program

Certificate of Coverage

2018 Benefit Year

It's Your Choice Local Traditional Plan

(Program Options 2/12)

Revised 9/20/17

UNIFORM BENEFITS

As of the 1994 coverage year, all HEALTH PLANS offering coverage in the Wisconsin Public Employers Group Health Insurance Program must provide the Uniform Benefits as described in this document. The HEALTH PLAN may not alter the language, benefits or exclusions and limitations of the Uniform Benefits plan. HEALTH PLANS are required to provide PARTICIPANTS with a description of any PRIOR AUTHORIZATION or REFERRAL requirements of the HEALTH PLAN.

TABLE OF CONTENTS

I. Schedule of Benefits

All benefits are paid according to the terms of this contract between the HEALTH PLAN(S), the PBM, and the Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the contract. The SCHEDULE OF BENEFITS describes certain essential dollar or visit limits of YOUR coverage and certain rules, if any, YOU must follow to obtain covered services. In some situations (for example, EMERGENCY services received from an OUT-OF-NETWORK PROVIDER), benefits will be determined according to the USUAL AND CUSTOMARY CHARGE.

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

This Summary Plan Description applies to services received from IN-NETWORK PROVIDERS. If any OUT-OF-NETWORK benefits are available, YOU will be provided with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by OUT-OF-NETWORK PROVIDERS. OUT-OF-NETWORK DEDUCTIBLE amounts do not accumulate to the IN-NETWORK OUT-OF-POCKET LIMIT (OOPL).

NOTE: - For PARTICIPANTS enrolled in a Preferred PROVIDER Plan (WEA Trust), this SCHEDULE OF BENEFITS applies to services received from in-network PLAN PROVIDERS. YOUR HEALTH PLAN will provide YOU with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by NON-PLAN PROVIDERS. Out-of-network DEDUCTIBLE amounts do not accumulate to the in-network OUT-OF-POCKET LIMIT.

Except as specifically stated for EMERGENCY and URGENT CARE (see Sections III, A, 1 and III, A, 2), YOU do not have coverage for services from OUT-OF-NETWORK PROVIDERS unless YOU receive a PRIOR AUTHORIZATION from YOUR HEALTH PLAN before such services are obtained.

The covered benefits are subject to the following: DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Benefits	**PARTICIPANTS enrolled in IYC Local Traditional Plan (PO 2/12) including those enrolled in MEDICARE**
Annual Medical **DEDUCTIBLE**	None.
Annual Medical **COINSURANCE**	BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids.
Annual Medical **OUT-OF-POCKET LIMIT (OOPL)**	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.[1]
Annual **MAXIMUM OUT OF POCKET (MOOP)**	$6,850 PARTICIPANT / $13,700 family limit. The MOOP is EMBEDDED
*Routine, **Preventive Services** as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.
Primary Care Office Visit COPAYMENT applies to: • Family Practice • General Practice • Internal Medicine • Gynecology/ Obstetrics • Midwives (if BENEFIT PLAN offers) • Nurse Practitioners • Physician Assistants • Chiropractic • Mental Health • Physical Therapy • Occupational Therapy • Speech Therapy	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.
Specialist COPAYMENT applies to: • Specialists • URGENT CARE	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.

Benefits	PARTICIPANTS enrolled in IYC Local Traditional Plan (PO 2/12) including those enrolled in MEDICARE
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT.
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no family limit.[2]
Cochlear Implants for PARTICIPANTS **age 18 and older**	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES. BENEFIT PLAN/ MEDICARE pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL or MOOP).
Cochlear Implants for PARTICIPANTS **under age 18**	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.
Hearing Aids for PARTICIPANTS **age 18 and older**. One aid per ear no more than once every 3 years.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL or MOOP). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.
Hearing Aids for PARTICIPANTS **under age 18**	As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 100%.
Temporo- mandibular Joint Disorders	BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN/ MEDICARE pays 100%. Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.
Dental Implants	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.
Prescription Drugs	See below.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP.

[2] Federally required preventive services are covered at 100%.

1) Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE

2) Ambulance: Covered as MEDICALLY NECESSARY for EMERGENCY or urgent transfers.

3) Diagnostic Services Limitations: PRIOR AUTHORIZATION may be required.

4) Outpatient Physical, Speech and Occupational Therapy Maximum (includes HABILITATION SERVICES or REHABILITATION SERVICES): Covered up to 50 visits per PARTICIPANT for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional MEDICALLY NECESSARY visits may be available when PRIOR AUTHORIZED by the HEALTH PLAN, up to a maximum of 50 additional visits per therapy per PARTICIPANT per calendar year.

5) Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when MEDICALLY NECESSARY and PRIOR AUTHORIZED by the HEALTH PLAN; and HOSPITAL CHARGES. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for PARTICIPANTS under 18 years of age are payable as described in the preceding grid.

6) Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum of $1,000 per hearing aid. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), hearing aids for PARTICIPANTS under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.

7) Home Care Benefits Maximum: 50 visits per PARTICIPANT per calendar year. 50 additional MEDICALLY NECESSARY visits per PARTICIPANT per calendar year may be available when authorized by the HEALTH PLAN.

8) HOSPICE CARE Benefits: Covered when the PARTICIPANT'S life expectancy is six months or less, as authorized by the HEALTH PLAN.

9) Transplants: Limited to transplants listed in Benefits and Services Section.

10) Licensed Skilled Nursing Home Maximum: 120 days per BENEFIT PERIOD payable for SKILLED CARE.

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

12) Vision Services: One routine exam per PARTICIPANT per calendar year. Non-routine eye exams are covered as MEDICALLY NECESSARY. (Contact lens fittings are not part of the routine exam and are not covered.)

13) Oral Surgery: Limited to procedures listed in Benefits and Services Section.

14) Temporomandibular Disorders as required by Wis. Stat. §632.895 (11): The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per PARTICIPANT per calendar year. Intraoral splints are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

15) Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services Section.

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

a) Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.

b) Preventive Prescription Drugs:

i) Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.

ii) The PBM will publish a list of prescriptions drugs affected by this provision.

Prescription Drug Copayments:
Level 1 COPAYMENT: $5.00
The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Prescription Drug Coinsurance:
Level 2 COINSURANCE: 20% ($50 max)
The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3 COINSURANCE: 40% ($150 max)
The Level 3 COINSURANCE applies to Non-Preferred BRAND NAME DRUGS and certain high-cost, GENERIC DRUGS for which alternative and/or equivalent Preferred GENERIC DRUGS and Preferred BRAND NAME DRUGS are available and covered.

Level 1/Level 2 Annual OOPL:
Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Local Traditional (PO2/12): $600 per individual or $1,200 per family for all PARTICIPANTS.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

Level 3 Annual OOPL:
Level 3 out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Local Traditional (PO2/12): no annual OOPL.

When the OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS
Specialty Drug Cost Share:
Level 4 COPAYMENT: $50
The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

If YOU do not have MEDICARE as YOUR primary coverage, YOU must use a PREFERRED SPECIALITY PHARMACY.

Level 4 COINSURANCE: 40% ($200 max)
The Level 4 COINSURANCE applies when any SPECIALTY MEDICATION is obtained from a PARTICIPATING PHARMACY other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $6,850 individual / $13,700 family.

The maximum annual amount YOU pay for YOUR Level 4 Preferred SPECIALTY MEDICATIONS.

Level 4 Preferred SPECIALTY MEDICATIONS out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Local Traditional (PO2/12): $1,200 per individual or $2,400 per family.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

3) Certain medications as defined by the PBM: Certain medications as defined by the PBM are available to YOU at a discount but are not covered by the BENEFIT PLAN. These medications may include drugs for weight loss, infertility, and erectile dysfunction. YOU will pay 100% of the cost of these medications.

4) **Disposable Diabetic Supplies and Glucometers:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOPL.

5) **Smoking Cessation:** One consecutive three-month course of pharmacotherapy covered per calendar year. PRIOR AUTHORIZATION is required if the first quit attempt is extended by the prescriber.

II. Definitions

The following terms, when used and capitalized in this Uniform Benefits description, are defined and limited to that meaning only:

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

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

3) Weighing YOUR options about what kind of care and treatment YOU would want or not want.

4) Making decisions about whether YOU want to appoint a health care agent and/or complete an advance directive.

5) Communicating YOUR wishes and any documents with YOUR family, friends, clergy, other advisors and physician and other health care professionals.

ALLOWED AMOUNT: Means the maximum amount on which payment is based for covered health care services. Generally this is composed of the PROVIDER's CHARGE, less any discount negotiated by the HEALTH PLAN.

BED AND BOARD: Means all usual and customary HOSPITAL CHARGES for: (a) Room and meals; and (b) all general care needed by registered bed patients.

BENEFIT PERIOD: Means the total duration of CONFINEMENTS that are separated from each other by less than 60 days.

BENEFIT PLAN: Means the BENEFIT PLAN design option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and GENERIC DRUG classifications.

CHARGE: An amount for a health care service from a PROVIDER that is reasonable, as determined by the HEALTH PLAN. The HEALTH PLAN considers, as part of determination of CHARGE:

1) Amounts charged for similar health care services in the same general area under comparable circumstances,

2) the HEALTH PLAN'S methodology guidelines,

3) pricing guidelines of any third party responsible for pricing a claim,

4) the negotiated rate determined between the HEALTH PLAN and an IN-NETWORK PROVIDER, and

5) other factors.

The term “area” means a county or other geographical area which the HEALTH PLAN determines is appropriate to obtain a representative cross section of amounts. For example, the “area” may be an entire state.

In some cases the amount the HEALTH PLAN determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other 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.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

COINSURANCE: A specified percentage of the CHARGES that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an IN-NETWORK PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the IN-NETWORK PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

DEPARTMENT: Means the State of Wisconsin Department of Employee Trust Funds.

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

1) Spouse.[1]

2) Child.[2, 3, 4]

3) Legal ward who becomes a permanent legal ward of the SUBSCRIBER or SUBSCRIBER'S spouse prior to age 19. [2, 3, 4]

4) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.[2, 3, 4]

5) Stepchild.[1, 2, 3, 4]

6) Grandchild if the parent is a DEPENDENT child.[2, 3, 4, 5]

[1] 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.

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

a) An unmarried DEPENDENT child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled 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. If the SUBSCRIBER should decease, the disabled adult DEPENDENT must still meet the remaining disabled criteria and be incapable of self-support. The CONTRACTOR will monitor eligibility annually, notifying the EMPLOYER and DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The CONTRACTOR will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the CONTRACTOR determination.

b) 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.

[3] 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 acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

[4] A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE.

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

DURABLE MEDICAL EQUIPMENT: See MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT.

EFFECTIVE DATE: The date, as certified by the DEPARTMENT and shown on the records of the HEALTH PLAN and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

ELIGIBLE EMPLOYEE: As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.

EMBEDDED: Means the individual portion of PARTICIPANT financial responsibility (DEDUCTIBLE, OOPL, MOOP) within the family's total financial responsibility. For example, when a PARTICIPANT within a family plan meets the individual DEDUCTIBLE, that PARTICIPANT is no longer responsible for any further DEDUCTIBLE. The remaining family DEDUCTIBLE will still apply to other family PARTICIPANTS.

EMERGENCY: Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of medical attention will likely result in any of the following:

1) Serious jeopardy to the PARTICIPANT'S health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.

2) Serious impairment to the PARTICIPANT'S bodily functions.

3) Serious dysfunction of one or more of the PARTICIPANT'S body organs or parts.

Examples of EMERGENCIES are listed in Section III, A, 1, d. EMERGENCY services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the HEALTH PLAN must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the HEALTH PLAN and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the HEALTH PLAN and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

FORMULARY: Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require PRIOR AUTHORIZATION for certain Preferred and NON-PREFERRED DRUGS before coverage applies. Drugs that are not included on the FORMULARY are not covered by the benefits of this program.

GENERIC DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

GENERIC EQUIVALENT: Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.

GRIEVANCE: Means a written complaint filed with the HEALTH PLAN and/or PBM concerning some aspect of the HEALTH PLAN and/or PBM. Some examples would be a rejection of a claim, denial of a formal REFERRAL, etc.

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

HEALTH PLAN: Means the health plan that is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A benefit plan that, under federal law, has a minimum annual DEDUCTIBLE and a maximum annual OOPL set by the IRS. An HDHP does not pay any health care costs until the annual DEDUCTIBLE has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The HDHP is designed to offer a lower monthly premium in turn for more shared health care costs.

HOSPICE CARE: Means services provided to a PARTICIPANT whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided through a licensed HOSPICE CARE PROVIDER approved by the HEALTH PLAN.

HOSPITAL: Means an institution that:

1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or

2) qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission of Accreditation of HOSPITALS.

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

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses.

INJURY: Means bodily damage that results directly and independently of all other causes from an accident.

IN-NETWORK PROVIDER: A PROVIDER who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The PROVIDER'S written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The HEALTH PLAN agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the HEALTH PLAN in advance of the services being provided.

LEVEL “M” DRUG: Means an injectable, prescription medication covered by MEDICARE Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. LEVEL M DRUGS are required to be on the MEDICARE PRESCRIPTION DRUG PLAN’S MEDICARE Part

D FORMULARY but are not included on the commercial coverage FORMULARY. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the HEALTH PLAN.

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the HEALTH PLAN after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT: Means items which are, as determined by the HEALTH PLAN:

1) Used primarily to treat an ILLNESS or INJURY, and

2) generally not useful to a person in the absence of an ILLNESS or INJURY, and

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

4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided 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 the HEALTH PLAN and/or PBM:

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 service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

MEDICARE: Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in MEDICARE Parts A and B, and eligible for

MEDICARE Part D; and who are covered under a MEDICARE coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

MEDICAID: Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MISCELLANEOUS HOSPITAL EXPENSE: Means usual and customary HOSPITAL ancillary CHARGES, other than BED AND BOARD, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this HEALTH PLAN.

NATURAL TOOTH: Means a tooth that would not have required restoration in the absence of a PARTICIPANT'S trauma or INJURY, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.

NON-EMBEDDED: Means that families must meet the full family amount before benefits are paid.

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM'S directory of PARTICIPATING PHARMACIES.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

1) Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician.

2) Re-assessment and intervention (individual and group).

3) Diabetes outpatient self-management training services (individual and group sessions).

4) Dietitian visit.

MAXIMUM OUT-OF-POCKET LIMIT (MOOP): Means the most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes YOUR premium, balance-billed charges or charges for health care that YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

OUT-OF-AREA SERVICE: Means any services provided to PARTICIPANTS outside the SERVICE AREA.

OUT-OF-NETWORK PROVIDER: A PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the HEALTH PLAN'S professional directory of providers. Care from an OUT-OF-NETWORK PROVIDER may require PRIOR-AUTHORIZATION from the HEALTH PLAN unless it is EMERGENCY or URGENT CARE.

OUT-OF-POCKET LIMIT (OOPL): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit. The most YOU pay during a policy period (usually a calendar year) for benefits considered essential health benefits under federal law. This limit never includes YOUR premium, balance-billed charges, charges for health care YOUR BENEFIT PLAN does not cover, or services that are not considered essential health benefits.

PARTICIPANT: The SUBSCRIBER or any of his/her DEPENDENTS who have been specified for enrollment and are entitled to benefits.

PARTICIPATING PHARMACY: Means a pharmacy who has agreed in writing to provide the services to PARTICIPANTS that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of PARTICIPATING PHARMACIES.

PHARMACY BENEFIT MANAGER (PBM): The PBM is a THIRD PARTY ADMINISTRATOR that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

POSTOPERATIVE CARE: Means the medical observation and care of a PARTICIPANT necessary for recovery from a covered surgical procedure.

PREFERRED DRUG: Means a drug the PBM has determined offers more value and/or cost-effective treatment options compared to a NON-PREFERRED DRUG. This would include Preferred GENERIC DRUGS, Preferred BRAND NAME DRUGS and Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program.

PREFERRED SPECIALTY PHARMACY: Means a PARTICIPATING PHARMACY which meets criteria established by the PBM to specifically administer SPECIALTY MEDICATION services, with which the PBM has executed a written contract to provide services to PARTICIPANTS, which are administered by the PBM and covered under the policy. The PBM may execute written contracts with more than one PARTICIPATING PHARMACY as a PREFERRED SPECIALTY PHARMACY.

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

PRIMARY CARE PROVIDER (PCP): Means an IN-NETWORK PROVIDER who is named as a PARTICIPANT'S primary health care contact. He/She provides entry into the health care system. He/She also (a) evaluates the PARTICIPANT'S total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other PROVIDER health services and refers the PARTICIPANT to other PROVIDERS.

YOU must name YOUR PCP on YOUR enrollment application. Each family PARTICIPANT may have a different PCP.

PRIOR AUTHORIZATION: Means obtaining approval from YOUR HEALTH PLAN before obtaining the services. Unless otherwise indicated by YOUR HEALTH PLAN, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the HEALTH PLAN and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

REFERRAL: When a PARTICIPANT'S PRIMARY CARE PROVIDER sends him/her to another PROVIDER for covered services. In many cases, the REFERRAL must be in writing and on the HEALTH PLAN PRIOR AUTHORIZATION form and approved by the HEALTH PLAN in advance of a PARTICIPANT'S treatment or service. REFERRAL requirements are determined by each HEALTH PLAN and are described in the It's Your Choice materials. The authorization from the HEALTH PLAN will state: a) the type or extent of treatment authorized; and b) the number of PRIOR AUTHORIZED visits and the period of time during which the authorization is valid. In most cases, it is the PARTICIPANT'S responsibility to ensure a REFERRAL, when required, is approved by the HEALTH PLAN before services are rendered.

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

SCHEDULE OF BENEFITS: The document that is issued to accompany this document which details specific benefits for covered services provided to PARTICIPANTS by the BENEFIT PLAN YOU elected.

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

SERVICE AREA: Specific zip codes in those counties in which the IN-NETWORK PROVIDERS are approved by the HEALTH PLAN to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a HEALTH PLAN or health care PROVIDER that PARTICIPANTS must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that PARTICIPANTS can decide the best possible course of treatment. The HEALTH PLAN or health care PROVIDER will provide the PARTICIPANT with written Patient Decisions Aids (PDAs) as part of the SDM program.

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

SKILLED NURSING FACILITY: Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a SKILLED NURSING FACILITY.

SPECIALTY MEDICATIONS: Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all PARTICIPATING PHARMACIES; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.

SUBSCRIBER: An ELIGIBLE EMPLOYEE or annuitant who is enrolled for (a) single coverage; or (b) family coverage and whose DEPENDENTS are thus eligible for benefits.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE

AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the HEALTH PLAN must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the HEALTH PLAN, when taking into consideration, among other factors determined by the HEALTH PLAN, amounts charged by health care PROVIDERS for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care PROVIDER as full payment for similar treatment, services and supplies. In some cases the amount the HEALTH PLAN determines as reasonable may be less than the amount billed. In these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. HEALTH PLAN approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the HEALTH PLAN must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

YOU/YOUR: The SUBSCRIBER and his or her covered DEPENDENTS.

III. Benefits and Services

The benefits and services provided under the Health Benefit Program are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the PARTICIPANT'S PRIMARY CARE PROVIDER (except in the case of IN-NETWORK chiropractic services, EMERGENCY or URGENT CARE), and are received after the PARTICIPANT'S EFFECTIVE DATE.

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the HEALTH PLAN reserves the right to determine in a reasonable manner the PROVIDER to be used. In cases of EMERGENCY or URGENT CARE services, IN-NETWORK PROVIDERS and HOSPITALS must be used whenever possible and reasonable (see item A, 1 and item A, 2 below).

Except as specifically stated for EMERGENCY and URGENT CARE, YOU must receive the HEALTH PLAN'S written PRIOR AUTHORIZATION for covered services from an OUT-OF-NETWORK PROVIDER or YOU will be financially responsible for the services. The HEALTH PLAN may also require PRIOR AUTHORIZATION for other services or they will not be covered.

Subject to the terms and conditions outlined herein and the attached SCHEDULE OF BENEFITS, a PARTICIPANT, in consideration of the employer's payment of the applicable HEALTH PLAN and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any COPAYMENT, COINSURANCE and other limitations shown in the SCHEDULE OF BENEFITS; and (b) all other terms and conditions outlined in this Uniform Benefits description. All services must be MEDICALLY NECESSARY, as determined by the HEALTH PLAN and/or PBM.

A. Medical/Surgical Services

1) EMERGENCY Care

a) Medical care for an EMERGENCY, as defined in Section II. Refer to the SCHEDULE OF BENEFITS for information on the EMERGENCY room COPAYMENT.

b) YOU should use IN-NETWORK HOSPITAL EMERGENCY rooms whenever possible. If YOU are not able to reach YOUR IN-NETWORK PROVIDER, go to the nearest appropriate medical facility. If YOU must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU call the HEALTH PLAN by the next business day or as soon as possible and tell the HEALTH PLAN where YOU received EMERGENCY care. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the HEALTH PLAN or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the HEALTH PLAN. In addition to the cost sharing described in the SCHEDULE OF BENEFITS, EMERGENCY care from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES.

c) It is recommended, to expedite claims processing, that YOU (or another individual on YOUR behalf) notify the HEALTH PLAN of EMERGENCY or URGENT CARE OUT-OF-NETWORK HOSPITAL admissions or facility CONFINEMENTS by the next business day after admission

or as soon as reasonably possible. This will help to expedite claims payment. OUT-OF-AREA SERVICE means medical care received outside the defined SERVICE AREA.

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

xiv) Any condition for which YOU are admitted to the HOSPITAL as an inpatient from the EMERGENCY room.

2) URGENT CARE

a) Medical care received in an URGENT CARE situation as defined in Section II. URGENT CARE is not EMERGENCY care. It does not include care that can be safely postponed until the PARTICIPANT can receive care from an IN-NETWORK PROVIDER.

b) YOU must receive URGENT CARE from an IN-NETWORK PROVIDER if YOU are in the SERVICE AREA, unless it is not reasonably possible. If YOU are out of the SERVICE AREA, go to the nearest appropriate medical facility unless YOU can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If YOU must go to an

OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU contact YOUR HEALTH PLAN by the next business day or as soon as possible and tell the HEALTH PLAN where YOU received URGENT CARE; this will expedite claims payment. URGENT CARE from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the HEALTH PLAN or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the HEALTH PLAN.

c) Some examples of URGENT CARE cases are:

i) Most broken bones,

ii) Minor cuts,

iii) Sprains,

iv) Most drug reactions,

v) Non-severe bleeding, and

vi) Minor burns.

3) Surgical Services
Surgical procedures, wherever performed, when needed to care for an ILLNESS or INJURY. These include:

a) PREOPERATIVE and POSTOPERATIVE CARE, and

b) Needed services of assistants and consultants.

This does not include oral surgery procedures, which are covered as described under item 16 of this section.

PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons associated directly or indirectly with the HEALTH PLAN for any PARTICIPANT who has not completed an optimal regimen of conservative care for low back pain (LBP). PRIOR AUTHORIZATION is not required for a PARTICIPANT who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PARTICIPANTS seeking surgical treatment of LBP must participate in a credible SHARED DECISION MAKING (SDM) program provided by the HEALTH PLAN or its contracted PROVIDERS consistent with the PRIOR AUTHORIZATION requirement.

4) Reproductive Services and Contraceptives
The following services do not require a REFERRAL to an IN-NETWORK PROVIDER who specializes in obstetrics and gynecology, however, the HEALTH PLAN may require that the PARTICIPANT obtain PRIOR AUTHORIZATION for some services or they may not be covered.

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b) Elective sterilization.

c) Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit in Section III, D.

ii) IUDs and diaphragms, as described under the DURABLE MEDICAL EQUIPMENT provision in item C, 3.

iii) Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

If the PARTICIPANT is in her second or third trimester of pregnancy when the PROVIDER'S participation in the BENEFIT PLAN offered by the HEALTH PLAN terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the HEALTH PLAN may request notification of the inpatient stay prior to the delivery or shortly thereafter.

5) Medical Services
MEDICALLY NECESSARY professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an IN-NETWORK PROVIDER (or a PROVIDER that was PRIOR AUTHORIZED by YOUR HEALTH PLAN).

a) Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

b) Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

c) Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

d) Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).

e) MEDICALLY NECESSARY travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the PARTICIPANT by the HEALTH PLAN. It does not apply to travel required for work. (See Exclusions, Section IV, A, 2, e.)

f) Injectable and infusible medications, except for SELF-ADMINISTERED INJECTABLE medications.

g) NUTRITIONAL COUNSELING provided by a participating registered dietician or an IN-NETWORK PROVIDER.

h) A second opinion from an IN-NETWORK PROVIDER or when PRIOR AUTHORIZED by the HEALTH PLAN.

i) Preventive services as required by the federal Patient Protection and Affordable Care Act.

6) Anesthesia Services
Covered when provided in connection with other medical and surgical services covered under these Uniform Benefits. It will also include anesthesia services for dental care as provided under item B, 1, c of this section.

7) Radiation Therapy and Chemotherapy
Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an IN-NETWORK PROVIDER.

8) Detoxification Services
Covers MEDICALLY NECESSARY detoxification services provided by an IN-NETWORK PROVIDER. Methadone Treatment shall be covered only when MEDICALLY NECESSARY and provided by an IN-NETWORK PROVIDER.

9) Ambulance Service
Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the HEALTH PLAN) when MEDICALLY NECESSARY to transport to the nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or URGENT in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger YOUR health. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the HEALTH PLAN'S SERVICE AREA, the HEALTH PLAN or IN-NETWORK PROVIDER should be contacted, if possible, before EMERGENCY or urgent transportation is obtained.

10) Diagnostic Services

MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PRIOR AUTHORIZATIONS are required for high-tech radiology tests, including MRI, CT scan, and PET scans.

11) Outpatient Rehabilitation, Physical, Speech and Occupation Therapy

MEDICALLY NECESSARY HABILITATION or REHABILITATION SERVICES and treatment as a result of ILLNESS or INJURY, provided by an IN-NETWORK PROVIDER. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the SCHEDULE OF BENEFITS, although up to 50 additional visits per therapy per calendar year may be PRIOR AUTHORIZED by the HEALTH PLAN if the therapy continues to be MEDICALLY NECESSARY and is not otherwise excluded.

12) Home Care Benefits

Care and treatment of a PARTICIPANT under a plan of care. The IN-NETWORK PROVIDER must establish this plan; approve it in writing; and review it at least every two months unless the physician determines that less frequent reviews are sufficient.

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

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

b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c) Physical, occupational and speech therapy. (These apply to the therapy maximum.)

d) MEDICAL SUPPLIES, drugs and medicines prescribed by an IN-NETWORK PROVIDER; and lab services by or for a HOSPITAL. They are covered to the same extent as if the PARTICIPANT was CONFINED IN A HOSPITAL.

e) NUTRITIONAL COUNSELING. A registered dietician must give or supervise these services.

f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

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

a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.

b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.

c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A PARTICIPANT may have been CONFINED IN A HOSPITAL just before home care started. If so, the home care plan must be approved, at its start, by the PROVIDER who was the primary PROVIDER of care during the HOSPITAL CONFINEMENT.

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the HEALTH PLAN if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the HEALTH PLAN. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the HEALTH PLAN.

Covers ADVANCE CARE PLANNING after the PARTICIPANT receives a terminal diagnosis regardless of life expectancy.

Covers a one-time in-home palliative consult after the PARTICIPANT receives a terminal diagnosis regardless of whether his or her life expectancy is 6 months or less.

HOSPICE CARE is available to a PARTICIPANT who is CONFINED. Inpatient CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a HEALTH PLAN-approved or MEDICARE-certified HOSPICE CARE facility.

When benefits are payable under both this HOSPICE CARE benefit and the Home Care Benefits, benefits payable under this subsection shall not reduce any benefits payable under the home care subsection.

14) Phase II Cardiac Rehabilitation

Services must be approved by the HEALTH PLAN and provided in an outpatient department of a HOSPITAL, in a medical center or clinic program. This benefit may be appropriate only for PARTICIPANTS with a recent history of:

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac REHABILITATION SERVICES are available under this contract.

15) Extraction of NATURAL TEETH and/or Replacement with Artificial Teeth Because of Accidental Injury

Total extraction and/or total replacement (limited to, bridge, denture or implant) of NATURAL TEETH by an IN-NETWORK PROVIDER when necessitated by an INJURY. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the HEALTH PLAN before the service is performed. Coverage of one retainer or mouth guard shall be provided when MEDICALLY NECESSARY as part of prep work provided prior to accidental INJURY tooth repair. INJURIES caused by chewing or biting are not considered to be accidental INJURIES for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

16) Oral Surgery

PARTICIPANTS should contact the HEALTH PLAN prior to any oral surgery to determine if PRIOR AUTHORIZATION by the HEALTH PLAN is required. When performed by IN-NETWORK PROVIDERS, approved surgical procedures are as follows:

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

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

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

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

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

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

g) Intraoral and extraoral incision and drainage of cellulitis.

h) Incision of accessory sinuses, salivary glands or ducts.

i) Reduction of dislocations of, and excision of, the temporomandibular joints.

j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

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

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

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

17) Treatment of Temporomandibular Disorders

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

a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

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

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

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

18) Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be PRIOR AUTHORIZED by the HEALTH PLAN in order to be a covered transplant. Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill.

Limited to one transplant per organ (which applies to items b., e., f., and g. as listed below) per PARTICIPANT per HEALTH PLAN during the lifetime of the policy, except as required for treatment of kidney disease.

a) Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:

i) Aplastic anemia

ii) Acute leukemia

iii) Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies

iv) Wiskott-Aldrich syndrome

v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

vi) Hodgkins and non-Hodgkins lymphoma

vii) Combined immunodeficiency

viii) Chronic myelogenous leukemia

ix) Pediatric tumors based upon individual consideration

x) Neuroblastoma

xi) Myelodysplastic syndrome

xii) Homozygous Beta-Thalassemia

xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

xiv) Multiple Myeloma, Stage II or Stage III

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

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

i) Corneal opacity

ii) 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

iii) Corneal ulcer

iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

i) Congestive Cardiomyopathy

ii) End-Stage Ischemic Heart Disease

iii) Hypertrophic Cardiomyopathy

iv) Terminal Valvular Disease

v) CONGENITAL Heart Disease, based upon individual consideration

vi) Cardiac Tumors, based upon individual consideration

vii) Myocarditis

viii) Coronary Embolization

ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

i) Extrahepatic Biliary Atresia

ii) Inborn Error of Metabolism

(1) Alpha -1- Antitrypsin Deficiency

(2) Wilson's Disease

(3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the HEALTH PLAN.

h) In addition to the above-listed diagnoses for covered transplants, the HEALTH PLAN may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the HEALTH PLAN determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

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

20) Chiropractic Services
When performed by an IN-NETWORK PROVIDER. Benefits are not available for MAINTENANCE CARE.

21) Women's Health and Cancer Act of 1998
Under the Women's Health and Cancer Act of 1998, coverage for medical and surgical benefits with respect to mastectomies includes:

a) Reconstruction of the breast on which a mastectomy was performed,

b) Surgery and reconstruction of the other breast to produce a symmetrical appearance,

c) Prostheses (see DURABLE MEDICAL EQUIPMENT in Section III, C, 3) and physical complications of all stages of mastectomy, including lymphedemas,

d) Breast implants.

22) Smoking Cessation
Coverage includes pharmacological products that by law require a written prescription and are described under the prescription drug benefits in Section III, D, 1, e. Coverage also includes 1 office visit for counseling and to obtain the prescription and four telephonic counseling sessions per calendar year. Additional counseling and/or limited extension of pharmacological products require PRIOR AUTHORIZATION by the HEALTH PLAN.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The HEALTH PLAN may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the HEALTH PLAN.

b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2) Outpatient Care
EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

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

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

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the HEALTH PLAN prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the HEALTH PLAN.

a) Outpatient Services
Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. “Outpatient services” means non-residential services by PROVIDERS as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37 and the federal Mental Health Parity and Addiction Equity Act (MHPAEA).

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

b) Transitional Services
Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. Transitional care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by MHPAEA.

c) Inpatient Services
Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS and as required by Wis. Stat. §632.89, Wis. Adm. Code § INS 3.37 and MHPAEA. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by an OUT-OF-NETWORK PROVIDER, if provided as required by an EMERGENCY detention or on an

EMERGENCY basis and the PROVIDER notifies the HEALTH PLAN within 72 hours after the initial provision of service.

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

2) Durable Diabetic Equipment and Related Supplies
When prescribed by an IN-NETWORK PROVIDER for treatment of diabetes and purchased from an IN-NETWORK PROVIDER, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered **subject to cost sharing as outlined in the SCHEDULE OF BENEFITS**. The PARTICIPANT'S COINSURANCE will be applied to the annual OOPL. Durable diabetic equipment includes:

a) Automated injection devices.

b) Continuing glucose monitoring devices.

c) Insulin infusion pumps, limited to one pump in a calendar year and YOU must use the pump for 30 days before purchase.

All DURABLE MEDICAL EQUIPMENT purchases or monthly rentals must be PRIOR AUTHORIZED as determined by the HEALTH PLAN.

(Glucometers are available through the PBM. Refer to Section III, D, 2 for benefit information.)

3) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT
When prescribed by an IN-NETWORK PROVIDER for treatment of a diagnosed ILLNESS or INJURY and purchased from an IN-NETWORK PROVIDER, MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT will be covered **subject to cost sharing as outlined in the SCHEDULE OF BENEFITS**.

The following MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT will be covered only when PRIOR AUTHORIZED as determined by the HEALTH PLAN:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the HEALTH PLAN, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

i) Ostomy and catheter supplies.

j) Oxygen and respiratory equipment for home use when authorized by the HEALTH PLAN.

k) Other medical equipment and supplies as approved by the HEALTH PLAN. Rental or purchase of equipment/supplies is at the option of the HEALTH PLAN.

l) When PRIOR AUTHORIZED as determined by the HEALTH PLAN, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the HEALTH PLAN will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the HEALTH PLAN. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the HEALTH PLAN. Additional visits may be approved by the HEALTH PLAN. If the student

is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any HEALTH PLAN under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
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 IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. These minimum coverage monetary amounts shall be adjusted annually beginning in 2011 as determined by the Office of Commissioner of Insurance. The therapy limit does not apply to this benefit.

D. Prescription Drugs and Other Benefits Administered by the PHARMACY BENEFIT MANAGER (PBM)

YOU must obtain pharmacy benefits at a PBM PARTICIPATING PHARMACY except when not reasonably possible because of EMERGENCY or URGENT CARE. In these circumstances, YOU may need to file a claim as described in the paragraph below.

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

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

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

1) Prescription Drugs

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

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The HEALTH PLAN, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED INJECTABLE).

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

Where a MEDICARE PRESCRIPTION DRUG PLAN is the primary payor, the PARTICIPANT is responsible for the COPAYMENT plus any charges in excess of the PBM ALLOWED AMOUNT. The ALLOWED AMOUNT is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

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

Prescription drugs will be dispensed as follows:

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

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

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

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

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED INJECTABLES and narcotics are among those for which a 90-day supply is not available.

i) Tablet splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 PREFERRED DRUGS that the PARTICIPANT can split the tablet of a higher strength dosage at home. Under this program, the PARTICIPANT gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. PARTICIPANTS who use tablet splitting will pay half the normal COPAYMENT amount.

j) The PBM reserves the right to designate certain over-the-counter drugs on the FORMULARY.

k) SPECIALTY MEDICATIONS and SELF-ADMINISTERED INJECTABLES when obtained by prescription and which can safely be administered by the PARTICIPANT, must be

obtained from a PBM PARTICIPATING PHARMACY OR PREFERRED SPECIALTY PHARMACY. In some cases, the PBM may need to limit availability to specific pharmacies.

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

2) Insulin, Disposable Diabetic Supplies, Glucometers
The PBM will list approved products on the FORMULARY. PRIOR AUTHORIZATION is required for anything not listed on the FORMULARY.

   a) Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30-consecutive-day supply for one prescription drug COPAYMENT, as described on the SCHEDULE OF BENEFITS.

   b) Disposable Diabetic Supplies and Glucometers will be covered after a 20% COINSURANCE as outlined in the SCHEDULE OF BENEFITS when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The PARTICIPANT'S COINSURANCE will be applied to the annual OOPL for prescription drugs.

3) Other Devices and Supplies
Other devices and supplies administered by the PBM that are subject to a 20% COINSURANCE and applied to the annual OOPL for prescription drugs are as follows:

   a) Diaphragms

   b) Syringes/Needles

   c) Spacers/Peak Flow Meters

IV. Exclusions and Limitations

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under Uniform Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by HEALTH PLANs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 10 applies only to the pharmacy benefit administered by the PBM. Some of the listed exclusions may be MEDICALLY NECESSARY, but still are not covered under this program, while others may be examples of services which are not MEDICALLY NECESSARY or not medical in nature, as determined by the HEALTH PLAN and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

   c) Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment.

2) Medical Services

   a) Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits and Services Section.

   b) Expenses for medical reports, including preparation and presentation.

   c) Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; or (c) treatment of flexible flat feet. This exclusion does not apply when services are performed by an IN-NETWORK PROVIDER to treat a metabolic or peripheral disease or a skin or tissue infection.

   d) Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include NUTRITIONAL COUNSELING as provided in the Benefits and Services Section.

   e) Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).

f) Services of a blood donor. MEDICALLY NECESSARY autologous blood donations are not considered to be services of a blood donor.

g) Genetic testing and/or genetic counseling services, unless MEDICALLY NECESSARY to diagnose or treat an existing ILLNESS.

3) Ambulance Services

a) Ambulance service, except as outlined in the Benefits and Services Section, unless authorized by the HEALTH PLAN.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, and mandated benefits for autism spectrum disorders under Wis. Stat. § 632.895 (12m) therapies.

c) Physical fitness or exercise programs.

d) Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.

e) Massage therapy.

5) Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental INJURY

a) All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in the Benefits and Services Section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening or lengthening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits and Services Section. (Note: Mandated TMJ benefits under Wis. Stat. § 632.895 (11) may limit this exclusion.)

b) All periodontic procedures, except gingivectomy surgery as listed in the Benefits and Services Section.

c) All oral surgical procedures not specifically listed in the Benefits and Services Section.

6) Transplants

a) Transplants and all related services, except those listed as covered procedures.

b) Services in connection with covered transplants unless PRIOR AUTHORIZED by the HEALTH PLAN.

c) Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per PARTICIPANT per HEALTH PLAN is covered during the lifetime of the policy, except as required for treatment of kidney disease.

d) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

e) All separately billed donor-related services, except for kidney transplants.

f) Non-human organ transplants or artificial organs.

7) Reproductive Services

a) Infertility services which are not for treatment of ILLNESS or INJURY (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an ILLNESS.

b) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c) Services for storage or processing of semen (sperm); donor sperm.

d) Harvesting of eggs and their cryopreservation.

e) 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.

f) Surrogate mother services.

g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) HOSPITAL Inpatient Services

a) Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b) HOSPITAL stays, which are extended for reasons other than MEDICAL NECESSITY, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c) A continued HOSPITAL stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, SKILLED NURSING FACILITY.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the HEALTH PLAN.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the HEALTH PLAN.

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

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the HEALTH PLAN.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the HEALTH PLAN. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED INJECTABLE medications.

j) Charges for supplies and medicines purchased from a NON-PARTICIPATING PHARMACY, except when EMERGENCY or URGENT CARE is required.

k) Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM'S Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.

l) Infertility and fertility medications.

m) Charges for medications obtained through a discount program or over the Internet, unless PRIOR AUTHORIZED by the PBM.

n) Charges to replace expired, spilled, stolen or lost prescription drugs.

11) General

a) Any additional exclusion as described in the SCHEDULE OF BENEFITS.

b) Services to the extent the PARTICIPANT is eligible for all MEDICARE benefits, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if the PARTICIPANT enrolled in MEDICARE coordinated coverage does not enroll in MEDICARE Part B when it is first available as the primary payor or who subsequently cancels MEDICARE coverage or is not enrolled in a MEDICARE Part D Plan.

c) Treatment, services and supplies for which the PARTICIPANT: (a) has no obligation to pay or which would be furnished to a PARTICIPANT without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

d) INJURY or ILLNESS caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.

e) Treatment, services and supplies for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.

f) Treatment, services and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services and supplies for which under the policy the HEALTH PLAN and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) MAINTENANCE CARE.

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

l) Personal comfort or convenience items or services such as in-HOSPITAL television, telephone, private room, housekeeping, shopping, homemaker services, and meal preparation services as part of home health care.

m) Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the BENEFIT PLAN.

n) Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.

o) Expenses incurred prior to the EFFECTIVE DATE of coverage by the HEALTH PLAN and/or PBM, or services received after the HEALTH PLAN and/or PBM coverage or eligibility terminates. Except when a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under HEALTH PLANS during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding HEALTH PLAN will be the responsibility of the succeeding HEALTH PLAN unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding HEALTH PLAN'S network. In this instance, the liability will remain with the previous HEALTH PLAN.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the HEALTH PLAN and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

   i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the HEALTH PLAN.

   ii. EMERGENCIES in the SERVICE AREA when the PRIMARY CARE PROVIDER or another IN-NETWORK PROVIDER cannot be reached.

   iii. EMERGENCY or URGENT CARE services outside the SERVICE AREA. Non-urgent follow-up care requires PRIOR AUTHORIZATION from the HEALTH PLAN.

v) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the HEALTH PLAN. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the HEALTH PLAN.

w) Coma stimulation programs.

x) Orthoptics (Eye exercise training) except for two sessions as MEDICALLY NECESSARY per lifetime. The first session for training, the second for follow-up.

y) Any diet control program, treatment, or supply for weight reduction.

z) Food or food supplements except when provided during a covered outpatient or inpatient CONFINEMENT.

aa) Services to the extent a PARTICIPANT receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation Act, employer's liability insurance plan or similar law or act. Entitled means YOU are actually insured under Worker's Compensation.

ab) Services related to an INJURY that was self-inflicted for the purpose of receiving HEALTH PLAN and/or PBM Benefits.

ac) Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires MEDICALLY NECESSARY treatment that is performed by an IN-NETWORK PROVIDER or PRIOR AUTHORIZED by the HEALTH PLAN. The treatment of the complication must be a covered benefit of the HEALTH PLAN and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any HEALTH PLAN as part of this program.

ad) Treatment, services and supplies for cosmetic or beautifying purposes, including removal of keloids resulting from piercing and hair restoration, except when associated with a covered service to correct a functional impairment related to CONGENITAL bodily disorders or conditions or when associated with covered reconstructive surgery due to an ILLNESS

or accidental INJURY (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.

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

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

ag) Sexual counseling services related to infertility.

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

ai) Hypnotherapy.

aj) Marriage/couples/family counseling.

ak) Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 and as required by the federal Mental Health Parity and Addiction Equity Act.

al) Biofeedback.

B. Limitations

1) COPAYMENTS or COINSURANCE are required for:

   a) State of Wisconsin program PARTICIPANTS, except for retirees for whom MEDICARE is the primary payor, for all services unless otherwise required under federal and state law.

   b) State of Wisconsin PARTICIPANTS for whom MEDICARE is the primary payor, and for all PARTICIPANTS of the Wisconsin Public Employers program, and/or limitations apply to, the following services: DURABLE MEDICAL EQUIPMENT, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.

2) Benefits are limited for the following services: Replacement of NATURAL TEETH because of accidental INJURY, Oral Surgery, HOSPITAL Inpatient, licensed SKILLED NURSING FACILITY, Physical, Speech and Occupational Therapy, Home Care Benefits, Transplants, Hearing Aids, and Orthoptics.

3) Use of OUT-OF-NETWORK PROVIDERS and HOSPITALS requires prior written approval by the PARTICIPANT'S PRIMARY CARE PROVIDER and the HEALTH PLAN to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

5) Circumstances Beyond the HEALTH PLAN'S and/or PBM'S Control: If, due to circumstances not reasonably within the control of the HEALTH PLAN and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the HEALTH PLAN and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the HEALTH PLAN, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

8) Only one transplant per organ per PARTICIPANT per HEALTH PLAN is covered during the lifetime of the policy, except as required for treatment of kidney disease.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section V, the following words are defined as follows:

ALLOWABLE EXPENSE: means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more PLANS covering the person for whom the claim is made. The difference between the cost of a private HOSPITAL room and the cost of a semi-private HOSPITAL room is not considered an ALLOWABLE EXPENSE unless the patient's stay in a private HOSPITAL room is MEDICALLY NECESSARY either in terms of generally accepted medical practice or as specifically defined by the PLAN. When a PLAN provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an ALLOWABLE EXPENSE and a benefit paid.

However, notwithstanding the above, when there is a maximum benefit limitation for a specific service or treatment, the SECONDARY PLAN will also be responsible for paying up to the maximum benefit allowed for its PLAN. This will not duplicate benefits paid by the PRIMARY PLAN.

CLAIM DETERMINATION PERIOD: means a calendar year. However, it does not include any part of a year during which a person has no coverage under THIS PLAN or any part of a year before the date this COB provision or a similar provision takes effect.

PLAN: means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:

1) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under MEDICAID (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does

not include any PLAN whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under a. or b. is a separate PLAN. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate PLAN.

PRIMARY PLAN / SECONDARY PLAN: The order of benefit determination rules state whether THIS PLAN is a PRIMARY PLAN or SECONDARY PLAN as to another PLAN covering the person.

When THIS PLAN is a SECONDARY PLAN, its benefits are determined after those of the other PLAN and may be reduced because of the other PLAN'S benefits.

When THIS PLAN is a PRIMARY PLAN, its benefits are determined before those of the other PLAN and without considering the other PLAN'S benefits.

When there are more than two PLANS covering the person, THIS PLAN may be a PRIMARY PLAN as to one or more other PLANS and may be a SECONDARY PLAN as to a different PLAN or PLANS.

THIS PLAN: means the part of YOUR Summary Plan Description (group contract) that provides benefits for health care and pharmaceutical expenses.

C. Order of Benefit Determination Rules

1) General
When there is a basis for a claim under THIS PLAN and another PLAN, THIS PLAN is a SECONDARY PLAN that has its benefits determined after those of the other PLAN, unless:

a) The other PLAN has rules coordinating its benefits with those of THIS PLAN, and

b) Both those rules and THIS PLAN'S rules described in subparagraph 2 require that THIS PLAN'S benefits be determined before those of the other PLAN.

2) Rules
THIS PLAN determines its order of benefits using the first of the following rules which applies:

a) Non-Dependent/DEPENDENT
The benefits of the PLAN which covers the person as an employee or PARTICIPANT are determined before those of the PLAN which covers the person as a DEPENDENT of an employee or PARTICIPANT.

b) DEPENDENT Child/Parents Not Separated or Divorced
Except as stated in subparagraph 2, c below, when THIS PLAN and another PLAN cover the same child as a DEPENDENT of different persons, called "parents":

i) The benefits of the PLAN of the parent whose birthday falls earlier in the calendar year are determined before those of the PLAN of the parent whose birthday falls later in that calendar year, but

ii) If both parents have the same birthday, the benefits of the PLAN which covered the parent longer are determined before those of the PLAN which covered the other parent for a shorter period of time.

However, if the other PLAN does not have the rule described in i) above but instead has a rule based upon the gender of the parent, and if, as a result, the PLANS do not agree on the order of benefits, the rule in the other PLAN shall determine the order of benefits.

c) DEPENDENT Child/Separated or Divorced Parents
If two or more PLANS cover a person as a DEPENDENT child of divorced or separated parents, benefits for the child are determined in this order:

i) First, the PLAN of the parent with custody of the child,

ii) Then, the PLAN of the spouse of the parent with the custody of the child, and

iii) Finally, the PLAN of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' PLANS have actual knowledge of those terms, benefits for the DEPENDENT child shall be determined according to C, 2, b.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the PLAN of that parent has actual knowledge of those terms, the benefits of that PLAN are determined first. This paragraph does not apply with respect to any CLAIM DETERMINATION PERIOD or PLAN year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d) Active/Inactive Employee
The benefits of a PLAN which covers a person as an employee who is neither laid off nor retired or as that employee's DEPENDENT are determined before those of a PLAN which covers that person as a laid off or retired employee or as that employee's DEPENDENT. If the other PLAN does not have this rule and if, as a result, the PLANS do not agree on the order of benefits, this paragraph d is ignored.

e) Continuation Coverage

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

(1) First, the benefits of a PLAN covering the person as an employee, member, or SUBSCRIBER or as a DEPENDENT of an employee, member, or SUBSCRIBER.

(2) Second, the benefits under the continuation coverage.

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

f) Longer/Shorter Length of Coverage
If none of the above rules determines the order of benefits, the benefits of the PLAN which covered an employee, member or SUBSCRIBER longer are determined before those of the PLAN which covered that person for the shorter time.

D. Effect on the Benefits of THIS PLAN

1) When This Section Applies
This section applies when, in accordance with Section C, Order of Benefit Determination Rules, THIS PLAN is a SECONDARY PLAN as to one or more other PLANS. In that event, the benefits of THIS PLAN may be reduced under this section. Such other PLAN or PLANS are referred to as "the other PLANS" in subparagraph 2 below.

2) Reduction in THIS PLAN'S Benefits
The benefits of THIS PLAN will be reduced when the sum of the following exceeds the ALLOWABLE EXPENSES in a CLAIM DETERMINATION PERIOD:

a) The benefits that would be payable for the ALLOWABLE EXPENSES under THIS PLAN in the absence of this COB provision, and

b) The benefits that would be payable for the ALLOWABLE EXPENSES under the other PLANS, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of THIS PLAN will be reduced so that they and the benefits payable under the other PLANS do not total more than those ALLOWABLE EXPENSES.

When the benefits of THIS PLAN are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of THIS PLAN.

E. Right to Receive and Release Needed Information

The HEALTH PLAN has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under THIS PLAN must give the HEALTH PLAN any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the HEALTH PLAN may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under THIS PLAN. The HEALTH PLAN will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the HEALTH PLAN is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1) The persons it has paid or for whom it has paid,

2) Insurance companies, or

3) Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the HEALTH PLAN and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the HEALTH PLAN and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the HEALTH PLAN, provide any relevant and reasonably available information which the HEALTH PLAN believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the HEALTH PLAN and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the HEALTH PLAN'S/PBM'S claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The HEALTH PLAN, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the HEALTH PLAN, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The HEALTH PLAN may employ a professional staff to provide case management services. As part of this case management, the HEALTH PLAN or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the HEALTH PLAN agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the HEALTH PLAN'S recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the HEALTH PLAN. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits 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 the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

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.

In situations where a PARTICIPANT 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 PROVIDER, disenrollment efforts may be initiated by the HEALTH PLAN or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The HEALTH PLAN and/or PBM might pay more than the HEALTH PLAN and/or PBM owes under the policy. If so, the HEALTH PLAN and/or PBM can recover the excess from YOU. The HEALTH PLAN and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the HEALTH PLAN and/or PBM.

Each PARTICIPANT agrees to reimburse the HEALTH PLAN and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the HEALTH PLAN and/or PBM. At the option of the HEALTH PLAN and/or PBM, benefits for future CHARGES may be reduced by the HEALTH PLAN and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a HEALTH PLAN or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the HEALTH PLAN provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The HEALTH PLAN'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

1) The third party or any liability or other insurance covering the third party.

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the HEALTH PLAN or DEPARTMENT to such extent.

The HEALTH PLAN'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the HEALTH PLAN'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the HEALTH PLAN'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the HEALTH PLAN or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the HEALTH PLAN or DEPARTMENT such additional information as is reasonably requested by the HEALTH PLAN or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the HEALTH PLAN'S or DEPARTMENT'S rights against a third party. The HEALTH PLAN or DEPARTMENT has no right to recover from a PARTICIPANT or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the PARTICIPANT'S or insured's comparative negligence. If a dispute arises between the HEALTH PLAN or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the HEALTH PLAN or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the HEALTH PLAN or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the HEALTH PLAN or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the HEALTH PLAN or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the

PARTICIPANT, in which case the HEALTH PLAN or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the HEALTH PLAN or DEPARTMENT for all amounts theretofore or thereafter paid by the HEALTH PLAN or DEPARTMENT which would have otherwise been recoverable under such acts and the HEALTH PLAN or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the HEALTH PLAN or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the HEALTH PLAN and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the HEALTH PLAN, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the HEALTH PLAN and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the HEALTH PLAN and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating HEALTH PLANs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the HEALTH PLAN'S and/or PBM'S administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the HEALTH PLAN and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the HEALTH PLAN and/or PBM. Contact the HEALTH PLAN and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the HEALTH PLAN'S and/or PBM'S GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT

complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the HEALTH PLAN and/or PBM. The HEALTH PLAN and/or PBM will advise YOU of YOUR right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the HEALTH PLAN and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through an external review process under applicable federal or state law. YOU may request an external review. In this event, YOU must notify the TPA and/or PBM of YOUR request. Any decision rendered through an external review is final and binding in accordance with applicable federal or state law. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the HEALTH PLAN'S or PBM'S GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an external review decision that is final and binding has been rendered in accordance with applicable federal or state law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the external review process available under applicable federal or state law. These appeals are reviewed only to determine whether the HEALTH PLAN and/or PBM breached its contract with the Group Insurance Board.

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

The Wisconsin 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: 711; 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: 711).

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: 711).

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：711）

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 711).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 711)

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 711)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: 711).

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: 711).

Laotian/Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ ຽ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwońpod numer 1-877-533-5020 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 711) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 711).

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: 711).