State of Wisconsin and Wisconsin Public Employers Group Health Insurance Program

Certificate of Coverage

2023 Benefit Year

Medicare Plus Plan

ET-4113 Revised 9/20/22

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MEDICARE PLUS Coverage

MEDICARE PLUS Benefits

This section is the **Certificate of Coverage** for **Medicare Plus Benefits** and applies to **Participants** enrolled in **Medicare Plus**. **Participants** covered under this section should be enrolled in **Medicare** Parts A and B. If they are not, they will have greater out-of-pocket costs for benefits as shown in Exclusions c and p.

Participants who are employed with a State or participating Local employer are not eligible to enroll in **Medicare Plus**. Retired State or participating Local **Participants** who are over age 65 and/or are eligible for Medicare are eligible to enroll.

A **Participant** insured on a State or participating Local retiree policy who is enrolled in the **Access Plan** or **SMP**, loses that coverage with **Medicare** eligibility and automatically becomes a **Participant** under the **Medicare Plus** coverage.

All **Benefits** are paid according to the terms of the **Contract**. The Outline of Coverage below describes certain essential dollar or visit limits of a **Participant's** coverage and certain rules, if any, a **Participant** must follow to obtain covered services. In some situations (for example, additional services received from a **Non-Participating Provider**), **Benefits** will be paid according to the usual and customary and **Reasonable Charges**.

The **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 Pharmacy Benefits for those who are covered under the **Health Benefit Program.**

1. Definitions

The following definitions apply to the **Medicare Plus Benefits**:

Assignment: Means that a **Participant's** physician or health care **Participating Provider** agrees (or is required by law) to accept the **Medicare**-approved amount as full payment for covered health care services.

Balance Bill: Means seeking to bill, charge, or collect a deposit, remuneration or compensation from; to file or threaten to file with a credit reporting agency; or to have any recourse against a **Participant** or any person acting on the **Participant's** behalf for health care costs for which the **Participant** is not liable. The prohibition on recovery does not affect the **Participant's** liability for any **Deductibles**, **Coinsurance**, or **Copayments**, or for **Premium** owed under the **Health Benefit Program**.

Benefit Period: Means the total duration of all successive **Confinements** that are separated from each other by less than 60 **Days**.

Charges: Means the reasonable charges for items or services set by **Medicare**. The **Contractor** treats **Charges** for stays in a **Hospital** or licensed skilled nursing facility as incurred on the date of admission. The **Contractor** treats all other **Charges** as incurred on the date the **Participant** gets the service or item. **Benefits** are payable only up to the reasonable charge set by **Medicare**, except as stated in Section VI.III.G.1.b. **Benefits** Available, below. No agreement between the **Participant** (or someone acting for the **Participant**) and any other person, group, or **Provider** of services will cause the **Health Benefit Program** to pay more.

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 the **Participant's** 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**.

Custodial Care: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a **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 **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.

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**, **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.

Effective Date: The date, as certified by the **Department** and shown on the records of the **Contractor** and/or **PBM**, on which the **Participant** becomes enrolled and entitled to the **Benefits** specified in the **Certificate of Coverage**.

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 **Contractor** 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 **Contractor** 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.

Effective Date: The date, as certified by the **Department** and shown on the records of the **Contractor** and/or **PBM**, on which the **Participant** becomes enrolled and entitled to the **Benefits** specified in the contract.

Grievance: Means a written complaint filed with the **Contractor** and/or **PBM** concerning some aspect of the **Contractor** and/or **PBM**.

Health Benefit Program: Means the program that provides group health **Benefits** to eligible State of Wisconsin and participating **Local Employees, Annuitants, Continuants** and their eligible **Dependents** in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the **Board**.

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 (formerly known as the Joint Commission on 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**.

Illness: Means a bodily disorder, bodily **Injury**, disease, mental disorder, or pregnancy. It includes conditions 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.

Lifetime Reserve Days: Means additional **Days** that **Medicare** will pay for when the **Participant** is in a **Hospital** for more than ninety (90) **Days**. The **Participant** has a total of sixty (60) reserve **Days** that can be used during their lifetime. For each lifetime reserve **Day, Medicare** pays all covered costs except for a daily **Coinsurance**.

Limiting Charge: Means the amount above the **Medicare**-approved amount billed by a **Non-Participating Provider** and allowed by **Medicare**.

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.

Medical Supplies And Durable Medical Equipment: Means items which are, as determined by the **Contractor**:

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 **Contractor** 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: Means benefits available under Title XVIII of the Social Security Act of 1965, as amended.

Medicare Part A Eligible Expenses and Medicare Part B Eligible Expenses: Means health care expenses that are covered by **Medicare** Part A or Part B, recognized as **Medically Necessary** and reasonable by **Medicare**, and that may or may not be fully reimbursed by **Medicare**.

Medicare Plus: Is a fee-for-service **Medicare** supplement plan administered by the **Contractor** for retirees enrolled in **Medicare** Parts A and B and pays for **Benefits** defined under this section.

Non-Affiliated Provider: Means (1) a physician or health care **Provider** that has decided not to provide services through **Medicare** and **Medicare** will not cover those services; or (2) a licensed health care **Provider** who is not allowed to bill Medicare for services.

Non-Participating Provider: Means that a physician or health care **Provider** has not signed an agreement to accept assignment for all **Medicare** covered services, but they can still choose to accept assignment for individual services.

Participant: Means a **Subscriber**, or any of his/her **Dependents**, covered by **Medicare** for whom proper application for **Medicare Plus** coverage has been made and for whom the appropriate **Premium** has been paid.

Participating Provider: Means that a physician or health care **Provider** that has signed an agreement to accept assignment for all **Medicare** covered services.

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**.

Reasonable Charges: Means an amount for a health care service that is reasonable, as determined by the **Contractor**. The **Contractor** takes into consideration, among other factors (including national sources) determined by the **Contractor**: (1) amounts charged by health care **Providers** for similar health care services when provided in the same geographical area; (2) the **Contractor's** methodology guidelines; (3) pricing guidelines of any third party responsible for pricing a claim; and (4) the negotiated rate determined by the **Contractor** in accordance with the applicable contract between the **Contractor** and a health care **Provider**. As used herein, the term "area" means a county or other geographical area which the **Contractor** determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. Also, the amount the **Contractor** 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)** unless the **Participant** 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.

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**.

Subscriber: Means an **Annuitant** or his/her surviving **Dependents** who have been specified by the **Department** to the **Benefit Plan** for enrollment and who is entitled to **Benefits**.

2. Outline of Coverage

Services and Supplies	Medicare Pays per Benefit Period (2022 information. Updated annually per CMS.)	Medicare Plus Pays (2022 information. Updated annually.)
Hospital Semiprivate room and board and miscellaneous HOSPITAL services and supplies such as drugs, x-rays, lab tests and operating room	First 60 **Days**, all but $1,556* 61st to 90th **Day**, all but $389* a **Day** 91st to 150th **Day**, all but $778* a **Day** (Lifetime Reserve) If **Lifetime Reserve Days** are exhausted, $0	Initial $1,556* deductible $389* a **Day** $778* 100% from the 91st to 120th **Day** of **Confinement**
Licensed Skilled Nursing Facility** **Medicare** covered services in a **Medicare** Approved Facility**	Requires a 3-**Day** period of **Hospital** stay First 20 **Days**, 100% of costs 21st - 100th **Days**, all but $194.50 a **Day** Beyond 100 **Days**, $0	Requires a 3-**Day** period of **Hospital** stay Not Applicable $194.50* a **Day** All covered services up to a maximum of 120 **Days** per **Benefit Period** **Custodial Care** is not covered
Licensed Skilled Nursing Facility** (**Non-Medicare Approved Facility**) If admitted within 24 hours following a **Hospital** stay	Covers only the same type of expenses normally covered by **Medicare** in a **Medicare** Approved Facility $0	Covers only the same type of expenses normally covered by **Medicare** in a **Medicare** Approved Facility Maximum daily rate for up to 30 **Days** per **Confinement**
Home Health Care** Under a doctor for part-time skilled nursing care, part-time home health aide care, physical therapy, occupational therapy, speech-language pathology services, medical social services.	100% of **Charges** for visits considered **Medically Necessary** by **Medicare**. Generally fewer than 7 **Days** a week, less than 8 hours a **Day** and 28 or fewer hours per week for up to 21 **Days**.	Up to 365 visits per year

Services and Supplies	Medicare Pays per Benefit Period (2022 information. Updated annually per CMS.)	Medicare Plus Pays (2022 information. Updated annually.)
Hospice Care **Medicare** certified program of terminal **Illness** care for pain relief and symptom management. Includes: nursing care; physician services; physical, occupational and speech therapy; social worker services; home health aids; homeworker services; medical supplies. First 180 **Days** and any **Medicare** approved extension	All covered services	**Coinsurance** or **Copayments** for all **Medicare** Part A Eligible Expenses
Hospice Facility	All but very limited **Coinsurance** for **Inpatient** respite care	**Medicare Copayment/Coinsurance** up to the equivalent **Reasonable Charges** of a skilled nursing facility
Miscellaneous Services Physical, speech and occupational therapy; ambulance; prosthetic devices; **Durable Medical Equipment**	After annual $233* **Medicare Deductible**, 80% of allowable **Charges**	Initial $233* **Deductible** and 20% of **Medicare** approved expenses
Physician's Services Includes medical care, surgery, home and office calls, dental surgeons, anesthesiologists, etc.	After annual $233* **Medicare Deductible**, 80% of allowable **Charges**	Initial $233* **Deductible** and 20% of **Medicare** approved expenses
Telemedicine, telehealth, or e-visit service	Not covered	100% of costs for allowable **Providers**
Drugs and Biologicals (non-hospitalization) Immunosuppressive drugs during the first year following a covered transplant Self-administered drugs prescribed by a physician	 After annual $233* **Medicare Deductible**, 80% of allowable **Charges** Not covered	 Initial $233 **Deductible** and 20% of **Medicare** approved expenses Refer to Pharmacy Benefit Manager portion of booklet for pharmacy **Benefits**

Services and Supplies	Medicare Pays per Benefit Period (2022 information. Updated annually per CMS.)	Medicare Plus Pays (2022 information. Updated annually.)
Outpatient Hospital Services In an emergency room or outpatient clinic, diagnostic lab and x-rays; medical supplies such as casts, splints, and drugs which cannot be self-administered	After the annual $233* **Medicare Deductible**, 80% of allowable **Charges**	Initial $233* **Deductible** and 20% of **Medicare** approved expenses
Psychiatric Treatment Other than **Hospital Inpatient**	After the annual $233* **Medicare Deductible**, 80% of the allowable **Charges**	Initial $233* **Deductible** and the amount, which combined with the **Medicare Benefit**, equals 20% of the **Reasonable Charges**
Private Duty Nursing While hospitalized and provided by an RN or LPN	$0	$0
Blood	After annual $233* **Medicare Deductible**, 80% of costs except non-replacement fees (blood **Deductible**) 1st 3 pints in each **Benefit Period**	Initial $233* **Deductible** and 20% of **Medicare** approved expenses

* Federal **Medicare Deductibles** are adjusted annually. Amounts shown above are for 2022. **Medicare Plus Benefits** are also adjusted annually to pay these **deductibles.**

** **Custodial Care** as defined is not covered.

3. Benefits Available

Benefits are payable for **Reasonable Charges** for the services and supplies described in sections d. through j. below on or after the **Effective Date** according to the terms, conditions and provisions of the **Contract**, if those services and supplies are consistent with and **Medically Necessary** for the admission, diagnosis and treatment of the **Participant**, as determined by the **Contractor**.

When services are provided by a **Non-Participating Provider, Benefits** are payable for amounts in excess of the **Medicare**-approved charge up to the lesser of the actual amount charged by the **Non-Participating Provider** and the **Limiting Charge**.

The **Benefits** listed below will automatically change to coincide with any changes in applicable **Medicare Deductible** amounts and **Coinsurance** percentage factors.

4. HOSPITAL INPATIENT Benefits

Benefits are payable for the **Medicare** Part A **Deductible** during the first sixty (60) **Days** of **Confinement**.

a. **Benefits** are payable for the **Medicare** Part A **Hospital** daily **Coinsurance** from the 61st to the 90th **Day** of a **Participant's Confinement**.

b. After a **Participant** has been in a **Hospital** for ninety (90) **Days, Medicare** pays an extra sixty (60) reserve **Days** during the **Participants** lifetime. **Benefits** are payable for the **Medicare** Part A **Hospital Coinsurance** for each reserve **Day** used by the **Participant**. If the **Participant** has exhausted the **Lifetime Reserve Days** during a previous **Benefit Period**, **Benefits** will continue to be payable for an additional thirty (30) **Days** of **Confinement** beginning on the 91st **Day** of **Confinement**. The **Provider** shall accept the **Contractor's** payment as payment in full and may not **Balance Bill** the **Participant**.

c. After **Medicare** pays its one hundred ninety (190) **Day** lifetime **Hospital Inpatient** psychiatric care **Benefits**, the **Benefit Plan** will pay the **Medicare Part A Eligible Expenses** for **Inpatient** psychiatric **Hospital** care for each **Day** a **Participant** is confined for psychiatric care beyond the **Medicare** lifetime limit but not to exceed a lifetime limit of one hundred seventy-five (175) **Days Confinement** under the **Benefit Plan**. **Benefits** will not exceed a total of three hundred sixty-five (365) **Days** for the **Participant's** lifetime.

d. **Benefits** are payable for the **Medicare** Part A **Eligible Expenses** for blood to the extent not covered by **Medicare**.

5. Services in a Licensed Skilled Nursing Facility

For **Confinement** in a licensed skilled nursing facility certified by and participating in **Medicare**, while the **Confinement** is covered by **Medicare**, **Benefits** are payable for such a **Confinement**, provided:

(1) a **Participant** receives care in a **Medicare** approved licensed skilled nursing facility and remains under continuous active medical supervision; and
(2) the **Participant** was a **Hospital Inpatient** for at least three (3) **Days** prior to **Confinement** in a licensed Skilled Nursing Facility.

Benefits are payable for up to a maximum of one hundred twenty (120) **Days** per **Benefit Period** beginning on the first day of admission to the licensed skilled nursing facility.

For **Confinement** in a licensed skilled nursing facility not participating in **Medicare**, or when the **Confinement** is not covered by **Medicare**, **Benefits** are payable provided the **Participant** is transferred within 24 hours of release from a **Hospital**. **Benefits** are payable up to the maximum daily rate established for **Skilled Care** in that facility by the Department of Health and Family Services for purposes of reimbursement under the Medical Assistance Program under Wis. Stats. § 49.45 to 49.47. **Benefits** are payable for such care at that facility up to thirty (30) **Days** per **Confinement**. **Benefits** are payable only if the attending physician certifies that the **Skilled Care Medically Necessary**. The physician must recertify this every seven (7) **Days**. **Benefits** are not payable for essentially domiciliary or **Custodial Care**, or care which is available to the **Participant** without charge or under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes).

6. Hospice Care

The **Contractor** shall pay a **Participant's Coinsurance** or **Co-Payments** for all **Medicare** Part A **Eligible Expenses** for Hospice Care and respite care. Hospice Care is available as long as the **Participant's** physician certifies that he/she is terminally ill and his/her care is eligible for payment under Part A of **Medicare**.

7. Professional and Other Services

Medicare Plus shall pay the **Medicare** Part B deductible and all **Medicare** Part B Eligible Expenses, to the extent not paid by **Medicare**, or in the case of **Hospital** outpatient department services paid under a prospective payment system, the **Copayment** amount, for the following services:

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

b. Chemotherapy in a physician's office, freestanding clinic or **Hospital** outpatient setting.

c. Prescription drugs covered by **Medicare** such as injections that can't be self-administered that a **Participant** receives in a physician's office, certain oral cancer drugs, drugs used with some types of **Durable Medical Equipment**, and under very limited circumstances, certain drugs a **Participant** receives in a **Hospital** outpatient setting.

d. Physical therapy, speech-language pathology services and occupational therapy when recommended by a physician.

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

f. Professional licensed ambulance service necessary to transport a **Participant** to or from a **Hospital** or licensed skilled nursing facility. Services include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance service is unavailable and such transportation is substantiated by a physician as being **Medically Necessary**.

g. Medical Supplies prescribed by a physician.

h. Rental of or purchase of **Durable Medical Equipment** such as, but not limited to: wheelchairs, walkers and hospital-type beds.

i. Outpatient cardiac rehabilitation services.

j. Facility fees for approved surgical procedures in an **Ambulatory Surgical Center**.

k. Blood processing and handling services for every unit of blood a **Participant** receives.

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

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

n. Diabetes supplies and self-management training.

p. Physician services that are **Medically Necessary** or provided in connection with preventive services covered by **Medicare. Benefits** are also payable for services provided by health care **Providers**, such as physician assistants, nurse practitioners, social workers, and psychologists.

q. Foot exams and treatment if a **Participant** has diabetes-related nerve damage and/or meets certain conditions determined by **Medicare**.

r. Kidney dialysis services and supplies. This includes dialysis medications, laboratory tests, home dialysis training and related equipment and supplies. In addition, **Benefits** are also payable for **Charges** for kidney disease education services prescribed by a physician.

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

t. Outpatient **Hospital** services, outpatient medical and surgical services and supplies.

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

v. Pulmonary rehabilitation programs if a **Participant** has moderate to severe chronic obstructive pulmonary disease prescribed by a physician.

w. Services for treatment of a surgical or surgically treated wound.

x. Tobacco smoking cessation counseling if a **Participant** is diagnosed with an **Illness** caused or complicated by tobacco use or takes a medicine that is affected by tobacco.

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

z. Glaucoma tests once every twelve (12) months for **Participants** at high risk for glaucoma.

8. Additional Services

Foreign Travel. Benefits are payable at 100% of the **Reasonable Charges** for **Medically Necessary** health care services received by a **Participant** in a foreign country.

Immunizations. Benefits are payable at 100% of the **Reasonable Charges** for immunizations not covered by **Medicare**.

Chiropractic Services. Benefits are payable at 100% of the **Reasonable Charges** for chiropractic services provided by a chiropractor within the scope of his/her license and not covered by **Medicare** per Wis. Stat. 632.875.

Home Care. Benefits are payable at 100% of the **Reasonable Charges** for home care services described below:

a. Covered Services. This section a.i. - a.vi. applies only if charges for home care services are not covered elsewhere under the **Contract**. A state licensed or **Medicare** certified home health agency or certified rehabilitation agency must provide or coordinate the services. A **Participant** should make sure the agency meets this requirement before services are provided. **Benefits** are payable for **Charges** for the following services when **Medically Necessary** for treatment:

   i. Part time or intermittent home nursing care by or under supervision of a registered nurse;
   ii. Part time or intermittent home health aide services when **Medically Necessary** as part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;
   iii. Physical, respiratory, occupational or speech therapy;
   iv. Medical Supplies, prescription drugs and Biologicals prescribed by a physician required to be administered by a professional **Provider**; laboratory services by or on behalf of a **Hospital**, if needed under the home care plan. These items are covered to the extent they would be if the **Participant** had been hospitalized;
   v. Nutrition counseling provided or supervised by a registered dietician;
   vi. Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. The **Participant's** attending physician must request or approve this evaluation.

   Note: Medicare Benefits will not be duplicated.

b. Limitations. The following limits apply to home care services:

   i. Home care is not covered unless the **Participant's** attending physician certifies that: (a) hospitalization or **Confinement** in a licensed skilled nursing facility would be needed if the **Participant** didn't have home care; and (b) members of the **Participant's Immediate Family** or others living with the **Participant** couldn't give the **Participant** the care and treatment he/she needs without undue hardship;
   ii. If the **Participant** was hospitalized just before home care started, the **Participant's** physician during the **Participant's Hospital** stay must also approve the home care plan;
   iii. **Benefits** are payable for **Charges** for up to three hundred sixty-five (365) home care visits in any 12-month period per **Participant**. Each visit by a person providing services under a home care plan, evaluating the **Participant's** need or developing a plan counts as one visit. Each period of up to four straight hours in a 24-hour period of home health aide service counts as one home care visit.
   iv. If home care is covered under two or more health insurance contracts or plans, coverage is payable under only one of them. The same is true if the **Participant** has home care coverage under the **Benefits** and another source;
   v. The maximum weekly **Benefit** for this coverage won't be more than the weekly **Charges** for **Skilled Care** in a licensed skilled nursing facility, as determined by the **Contractor**.

Equipment and Supplies for Treatment of Diabetes. Benefits are payable at 100% of the **Reasonable Charges** incurred for the installation and use of an insulin infusion pump, all other equipment and supplies, (except insulin and medical supplies for injection of insulin which include syringes, needles, alcohol swabs, and gauze) used in the treatment of diabetes, and **Reasonable Charges** for diabetic self-management education programs. This **Benefit** is limited to the purchase of one pump per calendar year. The **Participant** must use the pump for at least thirty (30) **Days** before the pump is purchased. **Medicare Benefits** won't be duplicated.

Benefits for Kidney Disease. Benefits are payable for **Reasonable Charges** for **Inpatient**, outpatient and home treatment of kidney disease, if not covered elsewhere under the **Health Benefit Program**. These services must be necessary for a **Participant's** diagnosis and treatment. This includes dialysis treatment and kidney transplantation expenses of both donor and recipient. There's a maximum of $30,000 per year for these **Benefits**. The **Contractor** will not pay for any **Charges** paid for, or covered by, **Medicare**.

Breast Reconstruction. Benefits are payable for **Reasonable Charges** for breast reconstruction of the affected tissue incident to a mastectomy.

Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care. Benefits are payable for **Reasonable Charges** for **Hospital** or **Ambulatory Surgery Center Charges** incurred, and anesthetics provided, in conjunction with dental care that is provided in a **Hospital** or **Ambulatory Surgery Center**, if any of the following applies:

a. The **Participant** is a child under the age of 5;

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

c. The **Participant** has a medical condition that requires hospitalization or general anesthesia for dental care.

Health Care Services Provided by a Non-Affiliated Provider. If a **Participant** receives services from a **Non-Affiliated Provider, Benefits** will be payable for **Reasonable Charges** for those services provided the services are covered under this section.

9. Exclusions

The following services are excluded from **Benefits**, except as otherwise specifically provided:

a. Health care services **Medicare** does not cover, unless the **Health Benefit Program** specifically provides for them.

b. Health care services which neither a **Participant** nor a party on the **Participant's** behalf has a legal obligation to pay in the absence of insurance.

c. Health care services to the extent that they are paid for by **Medicare** or would have been paid for by **Medicare** if a **Participant** is enrolled in **Medicare** Parts A and B; health care services to the extent that they are paid for by another government entity or program, directly or indirectly. This means that except in cases of fraud, if the **Participant** either does not enroll in **Medicare**

Part B at the time the **Participant** enrolls in a **Medicare** coordinated benefit plan and when **Medicare** is first available as the primary payer, or if the **Participant** cancels **Medicare** coverage, the **Participant's** coverage will be limited, and the **Participant** will be responsible for any costs that **Medicare** would have paid.

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

e. **Custodial Care**, including maintenance care and supportive care.

f. Cosmetic surgery.

g. Health care services received by a **Participant** before his/her coverage becomes effective or after coverage ends.

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

i. Health care services received outside the United States, except as specifically stated in Section V.I.III.H. Additional Services.

j. Amounts billed by a physician exceeding the MEDICARE approved amount, except as specifically stated in Section E. **Medicare Plus Benefits**.

k. Health care services which are not **Medically Necessary** as determined by the **Contractor**, except for such health care services that **Medicare** covers.

l. Routine physical exams and any related diagnostic X-ray and laboratory tests not covered by **Medicare**.

m. Private duty nursing.

n. Routine dental care.

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

p. 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.

10. Miscellaneous Provisions

a) Right to Obtain and Provide Information

Each **Participant** agrees that the **Contractor** 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 **Contractor** and/or **PBM** to evaluate in connection with its treatment, payment, or health care operations. Each person claiming **Benefits** must, upon request by the **Contractor**, provide any relevant and reasonably available information which the **Contractor** 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 to the **Contractor** and/or **PBM** but also disclosures to:

i. Health care **Providers** as necessary and appropriate for treatment,
ii. Appropriate **Department** employees as part of conducting quality assessment and improvement activities, or reviewing the **Contractor's/PBM's** claims determinations for compliance with **Contract** requirements, or other necessary health care operations,
iii. The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

b) Physical Examination

The **Contractor**, 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 their eligibility for claimed services or **Benefits** (including, without limitation, issues relating to subrogation and coordination of **Benefits**). By execution of an application for coverage under the **Health Benefit Program**, each **Participant** shall be deemed to have waived any legal rights they may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

c) Case Management/Alternate

The **Contractor** may employ professional staff to provide case management services. As part of this case management, the **Contractor** 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:

i. The recommended treatment offers at least equal medical therapeutic value, and
ii. The current treatment program may be changed without jeopardizing the **Participant's** health, and
iii. The **Charges** (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the **Contractor** agrees to the attending physician's recommendation or if the **Participant** or his/her authorized representative and the attending physician agree to the **Contractor'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 **Contractor**. The **PBM** may establish similar case management services.

d) Disenrollment

No person other than a **Participant** is eligible for **Benefits**. The **Subscriber's** rights to **Benefits** coverage are 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 **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 **Contractor** 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 **Contractor** and/or **PBM** might pay more than the **Contractor** and/or **PBM** owes under this **Agreement**. If so, the **Contractor** and/or **PBM** can recover the excess from the **Participant**. The **Contractor** 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 **Contractor** and/or **PBM**.

Each **Participant** agrees to reimburse the **Contractor** 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 **Contractor** and/or **PBM**. At the option of the **Contractor** and/or **PBM**, **Benefits** for future **Charges** may be reduced by the **Contractor** and/or **PBM** as a set-off toward reimbursement.

f) Limit on Assignability of Benefits

A **Participant** cannot assign any benefit to another person other than a physician, **Hospital** or other **Provider** entitled to receive a specific benefit for the **Participant**.

g) Severability

If any part of this **Agreement** is ever prohibited by law, it will no longer apply. The rest of this **Agreement** will continue in full force.

h) Subrogation

Each **Participant** agrees that the payer under **Medicare Plus** plan, whether that is the **Contractor** or the **Department**, shall be subrogated to a **Participant's** rights to damages, to the extent of the **Benefits** the **Contractor** provides under this **Agreement**, 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 **Contractor's** or **Department's** rights of full recovery may be from any source, including but not limited to:

i. The third party or any liability or other insurance covering the third party.
ii. The **Participant's** own uninsured motorist insurance coverage.
iii. Under-insured motorist insurance coverage.
iv. 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 **Contractor** or **Department** to such extent.

The **Contractor'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 **Contractor's** or **Department's** prior written consent shall be deemed to prejudice the **Contractor's** or **Department's** rights. Each **Participant** shall promptly advise the **Contractor** or **Department** in writing whenever a claim against another party is made on behalf of a **Participant** and shall further provide to the **Contractor** or **Department** such additional information as is reasonably requested by the **Contractor** or **Department**. The **Participant** agrees to fully cooperate in protecting the **Contractor's** or **Department's** rights against a third party. The **Contractor** 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 **Contractor** or **Department** and the **Participant** over the question of whether or not the **Participant** has been "made whole", the **Contractor** 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 **Illness** or **Injury** for which the **Contractor** 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 **Contractor** or **Department** the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the **Contractor** or **Department** in writing to prosecute such claim on behalf of and in the name of the **Participant**, in which case the **Contractor** 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 **Agreement**, 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 **Contractor** or **Department** for all amounts theretofore or thereafter paid by the **Contractor** or **Department** which would have otherwise been recoverable under such acts and the **Contractor** 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 **Agreement**. The **Participant** shall advise the **Contractor** 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

It is the **Participant's** responsibility to notify their **Provider** of the **Participant's** participation in the **Medicare Plus** plan. Failure to do so could result in a delay in the **Participant's** claim being paid.

If the services were received outside the United States, the **Participant** must indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of the **Participant's** claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the **Contractor** and/or **PBM** does not receive the **Participant's** claim within twelve (12) months, or if later, as soon as reasonably possible, after the date the service was received, the **Contractor** and/or **PBM** may deny coverage of the claim.

j) GRIEVANCE Process

The **Contractor** and the **PBM** are required to make a reasonable effort to resolve **Participants'** problems and complaints. If the **Participant** has a complaint regarding the **Contractor's** and/or **PBM's** administration of **Benefits** (for example, denial of claim or referral), the **Participant** should contact the **Contractor** and/or **PBM** and try to resolve the problem informally. If the problem cannot be resolved in this manner, the **Participant** may file a written **Grievance** with the **Contractor** and/or **PBM**. **Participants** should be directed to contact the **Contractor** and/or **PBM** for specific information on its **Grievance** procedures.

If the **Participant** exhausts the **Contractor's** and/or **PBM's Grievance** process and remains dissatisfied with the outcome, the **Participant** may appeal to the **Department** by completing a **Department** complaint form. The **Participant** should also submit copies of all pertinent documentation including the written determinations issued by the **Contractor** and/or **PBM**. The **CONTRACTOR** and/or **PBM** will advise the **Participant** of the **Participant's** right to appeal to the **Department** within sixty (60) **Days** of the date of the final **Grievance** decision letter from the **Contractor** and/or **PBM**.

However, the **Participant** 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 the HHS-administered federal External Review Process. The **Participant** may request an external review pursuant to federal law. In this event, the **Participant** must notify the **Contractor** and/or **PBM** of their request. In accordance with federal law, any decision by an HHS-administered federal external review is final and binding. The **Participant** shall have no further right to administrative review once the external review decision is rendered.

k) Appeals to the BOARD

After exhausting the **Contractor's** or **PBM's Grievance** process and review by the **Department**, the **Participant** may appeal the **Department's** determination to the **Board**, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The **Board** does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of **Benefits** under this section, 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 HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the **Contractor** and/or PBM breached its contract with the **Board**.