Member Guide

EPIC LIFE INSURANCE

WPS HEALTH INSURANCE®

The following paragraph applies when your application for insurance is included in your Member Guide.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of the application attached to your policy that's contained in this Member Guide. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to WPS Underwriting Department within 10 days if any information shown on the application is not correct and complete or if any requested medical history has not been included. Our address is: Health Underwriting, WPS Health Insurance, P.O. Box 7898, Madison WI 53707-7898. The application is part of the insurance policy. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

12449-051-0604

Please also see the provision called "Copy of Your Individual Policy Application" at the bottom of the second page of this Member Guide and the copy of your application for your insurance that's the last document contained in this Member Guide.

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Welcome to WPS!

We're pleased you've chosen WPS to take care of your benefits needs. As one of our valued customers, you can be assured top-notch benefits and service.

As you come to know us, you'll find a philosophy of service that lies at the heart of all our operations. Our employees understand the importance of sound coverage and share a keen understanding of our customers' service expectations. You'll find a dedication to giving you the absolute best in personal attention and service throughout all areas of our organization.

We're committed to, and value, the relationship we have with our customers. We'll provide solutions to your problems, do what we promise, and do what it takes to ensure your satisfaction with our products and services.

If your plan contains health and/or vision coverage, your plan is administered and underwritten by Wisconsin Physicians Service (WPS) Insurance Corporation. If your plan contains life and/or disability coverage, your plan is administered by WPS and underwritten by The EPIC Life Insurance Company. EPIC is a wholly-owned WPS subsidiary.

We designed this Member Guide to help you understand your benefit plans. Please take some time to review the Member Guide. If you have questions not addressed in the guide, or on any aspect of your benefits, please call your WPS Customer Service Representative at the number shown on your ID card.

We're looking forward to a long and healthy relationship with you.

HOW TO USE YOUR MEMBER GUIDE

Your Member Guide contains the following sections:

General Information

This section provides important information for you based on the types of coverage you have selected. It includes information about our services and may also include information on your drug plan, pre-certification requirements, and managed behavioral health care services.

Provider Information

This section includes information on how to access all the hospitals, facilities, and clinics as well as primary care physicians, specialty care physicians, and other health care providers that are preferred providers under your health plan.

Medical Benefits

This section describes the benefits available to you under your health plan. It includes a schedule of benefits (if applicable), certificate of insurance/policy; or benefits booklet and any appropriate endorsements. The schedule of benefits describes the coverages and provisions which apply to you and your covered dependents, if any. The certificate, policy or benefits booklet explains in detail the specific definitions, terms and conditions of your plan. Endorsements describe any additional benefits or any changes in your benefits or the terms of your coverage.

GENERAL INFORMATION

YOUR HEALTH PLAN ID CARD

Whenever you or your covered dependents receive care, please present your ID Card to the provider's office staff. This information is needed by them to complete any claims for payments.

Important things to remember:

- Carry your ID Card at all times
- Present it when you receive any covered service
- Notify our Customer Service Department if it is lost or stolen
- It's illegal to let anyone else use your ID Card

If you need additional ID Cards, please contact our Customer Service Department at the number shown on your ID Card or at 1-800-221-5313.

CUSTOMER SERVICE

What to do if you have questions about your benefits:

Our Customer Service Department is prepared to answer questions about your benefits. Be sure to tell us the customer number shown on your ID Card whenever you call or write us.

To call, please call the toll-free number shown on your ID Card.

To write, please correspond to the WPS address shown on your ID Card and include "Attention: Customer Service".

When to call our Customer Service Department:

- For an explanation of your covered benefits
- For additional or replacement ID Cards
- For benefits and eligibility information
- To find out whether a particular health care provider is a preferred provider

CHANGES IN COVERAGE STATUS

To make sure you receive the coverage you're entitled to, it's important you notify us about changes in status. If you're part of a group plan, you can notify your employer of such changes. If you have an individual policy, please contact our Customer Service Department.

Whenever you are requesting coverage for a new spouse or dependent, or changing existing coverage (i.e., single to family or family to single), you must complete an enrollment application and return it to us within the time period specified in your benefit plan information. If you apply for coverage outside of the specified time periods and/or you have an individual policy, some requests for coverage may require health underwriting.

Name change - Submit an enrollment application with the appropriate name change(s).

Your marriage - You may apply for coverage for your spouse within 31 days of marriage.

Newborn children, grandchildren, and newly adopted or prospective adoptive children - Requirements differ for adding newborn children, grandchildren, and newly adopted or prospective adoptive children. For further details, please refer to your certificate of insurance, benefits booklet or policy.

Marriage of a covered dependent - If a covered dependent marries, coverage for that dependent ends on the date he/she marries.

Covered dependent reaching limiting age - If a covered dependent reaches the limiting age identified in your benefit information, he/she is no longer eligible for coverage under your benefit plan.

Divorce or Annulment - Your covered spouse's coverage ends on the date you are no longer married due to divorce or annulment.

Death of a member, spouse or dependent - Coverage ends on the last day of the calendar month in which the death occurs.

If a participant's coverage ends, he/she may be eligible for state continuation of coverage, federal continuation (COBRA) coverage, or a conversion policy. For further details, please see the appropriate sections of your certificate of insurance, benefits booklet or policy.

A certificate of insurance, benefits booklet, or policy is included in or with this Member Guide. Please review this information for answers to any eligibility questions you may have. If you need further assistance, please do not hesitate to contact our Customer Service Department at the number shown on your ID card.

MISCELLANEOUS COVERAGE ISSUES

If you have any questions about the following coverage issues or any other aspect of your coverage, please feel free to call our Customer Service Department at the number shown on your ID Card.

- **Dependent -** Most of our benefit plans cover children who are dependents until they reach a specific age. Please refer to your certificate, benefits booklet, or policy for specific requirements. Dependents over the age of 19 may be asked to submit verification of eligibility.

- **Other Insurance Coverage -** You must tell your provider and us if you or any family member enrolled in our benefit plan is also covered by another health insurance or health benefits plan. If so, we'll coordinate benefits with the other plan.

  Coordination means that whenever two or more plans are involved, the plans work together to pay up to 100% of the covered charges - but not more. If you have questions about coordination of benefits, please call our Customer Service Department.

- **Medicare Carve-Out -** If covered charges are incurred by a member who is eligible to apply for Medicare, we will determine the benefits, if any, payable for those charges for covered health care services using our Medicare "Carve-Out" method. A member who is eligible for Medicare is considered enrolled in and covered under Medicare Parts A and B, whether or not he/she is actually enrolled in one or both parts of Medicare. For example, if a member is eligible to enroll in Medicare Part B, but fails to do so, or terminates his/her Medicare Part B coverage, we will still determine the covered benefits payable under the policy as if that member had Medicare Part B coverage and Medicare paid Part B benefits, even if Medicare didn't pay any Part B benefits.

HOW TO FILE CLAIMS

How Do My Claims Get Processed?

- Present your ID Card to your provider at the time of your visit.
- Most providers will file your claim for you. They may need additional information from you, such as whether you have other group medical coverage, before filing claims. If this does not occur, please contact your provider for a copy of the completed claim or itemized bill and forward it to the address shown on your ID Card. A specialized claim form isn't needed.
- Both you and your provider will receive an Explanation of Benefits (EOB) explaining the processing of your claim. Payments will be forwarded directly to your provider unless otherwise indicated on the claim.

If you have a question, please contact our Customer Service Department at the toll-free phone number shown on your ID Card. To efficiently serve your needs, please present your customer number (shown on your ID Card) when placing the call.

What Should be Submitted?

Written proof of your claim should be submitted within 120 days of the date on which you receive the health care service and should contain the following items:

- Your customer number.
- The actual itemized bill for each health care service, including the diagnosis.
- The patient's name, date of birth, and nickname, if applicable, on each bill.
- If applicable, attach an Explanation of Benefits from another insurance company.
- Finally, please note if the bill(s) has been paid.

Send the bill(s) to the address shown on your ID card.

Should you have any questions, please feel free to call us between the hours of:

7:00 a.m. and 7:00 p.m., CST - Monday through Thursday

7:00 a.m. and 4:30 p.m., CST - Friday

A Few Words About Quality Assurance

At WPS Health Insurance, We've successfully created harmony among quality of care, choice in providers, and cost containment. We're able to create products and services that go beyond the norm, safeguarding the avenues to quality, affordable health care for our customers.

We evaluate the effectiveness of our quality assurance program by the quality of care our customers receive on an ongoing basis. Using a personal approach of educating our provider partners, we strive to achieve the very best in coordinated care for our customers. We regularly monitor the quality of service provided to our customers by our provider partners using a number of tools, including Integrated Care Management (ICM), a Clinical Quality Team, and out Physician Advisory Council.

ICM

Through our nationally accredited ICM program, we identify quality issues as they pertain to individual health care providers. Our in-house staff of nurses and physician advisors review quality issues in daily utilization management rounds or weekly clinical case management meetings to determine if the issue is an isolated one or part of a trend with the provider. Recommendation actions, determined on a case-by-case basis, could include: case closure with no further action, continued monitoring, or referral to our WPS Medical Director or Clinical Quality Management Team for review and further action. In all instances, we document and retain issues and their resolution as indications of patterns of quality concern.

Clinical Quality Management Team

Our Clinical Quality Management Team comprises a Physician Adviser, three nurses, an attorney, and a member of our Plan Development (Provider Relations) staff, all of whom have proven experience in quality improvement methods and procedures. This team meets monthly to review referrals on quality concerns and to discuss the results of clinical quality initiatives.

Physician Advisory Council

We understand that providers are the most essential link in the health care delivery system. Therefore, through our Physician Advisory Council, we can foster an environment where physicians can gather to voice their opinions and discuss the many challenging and provocative issues facing the field of medicine. Our Physician Advisory Council brings together distinguished physicians with varying specialties, backgrounds, and geographical locations on a quarterly basis. In this forum, we can obtain valuable feedback about our organization and service, current health care issues, quality of care, the overall health care industry, and the future of medicine. Through this open exchange, we can ultimately improve our service to our customers and to our provider partners.

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MEMBERS' RIGHTS AND RESPONSIBILITIES

As a member of WPS Health Insurance Company, we believe you have certain basic rights and responsibilities regarding your health care.

You have the Right To:

1. Be treated with respect and recognition of your dignity and your right to privacy. You also have the right to privacy of your medical information received by us unless you allow the release of such information.
2. Participate with your physician or other health care provider in any decision making regarding your health care.
3. Have a candid discussion of appropriate or medically necessary treatment options for your medical condition.
4. Receive the right care at the right level at the right time by the right type of provider for your medical condition.
5. Receive information about preventive health care that is age and sex specific, and information about remaining as healthy as possible including self care and maintenance care for specific chronic diseases.
6. Receive care according to federal and state mandates.
7. Voice complaints or appeals about service from WPS Health Insurance or about care received.

You Have the Responsibility To:

1. Provide, to the extent possible, information that WPS Health Insurance and your physician or health care provider need to care for you.
2. Be aware of your health care coverage and requirements/limitations under your certificate of coverage, including , but not limited to, precertification or prior authorization requirements and exclusions.
3. Ask questions about your diagnosis, your treatment plan and how to best manage your health.
4. Follow the plans and instructions for care on which you have agreed with your physician or other health care provider.

What is Fraud?
Health care fraud is the deliberate submission of false information to gain undeserved payment on a claim.

What is Abuse?
Abuse involves a questionable practice, which is inconsistent with accepted medical or business policies. While not an intentional misrepresentation, it may result in unnecessary costs.

Who can commit Fraud or Abuse?
Anyone!

What are the warning signs?
Items or services on your Explanation of Benefits which:

- You didn't receive
- Are different from those you received
- Are unnecessary, inappropriate, or of questionable medical benefit
- Are billed under a different name than the individual who provided the service

A health care provider who:

- Routinely waives your deductible and coinsurance costs
- Offers "free" items or services to you, but then bills them to WPS
- Always requires his or her patients to pay the entire bill on the day the service is provided

Any person (other than a covered dependent) who uses your insurance identification card to obtain medical care

How does Fraud and Abuse affect you?
When a health care provider files a claim for a service you didn't receive, he or she is altering your health care history with false information. This false information could:

- Affect your future ability to obtain life or health insurance
- Increase your insurance premiums
- Affect the health care you receive from other providers

You can help stop Fraud and Abuse

- Know the warning signs
- Read your Explanation of Benefits (EOB) and make sure you received all of the services listed
- Call our toll-free hotline if you suspect fraud or abuse

How can I report Fraud or Abuse?
Call our toll-free Fraud and Abuse Hotline at 1-888-766-4681

Visit us on the Web at: **www.wpsic.com**

Or, write to us at:

> **WPS Special Investigations Unit**
> **P.O. Box 8190**
> **Madison, WI 53708-8190**

You'll need to tell us:

- Your name, address, and telephone number
  (If requested, you may remain anonymous)
- Your WPS Customer Identification Number
- The name and address of the health care provider
- An explanation of what you suspect to be Fraud or Abuse

All information will be kept strictly confidential.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain provider or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contract your issuer.

This statement applies to any individual or group contract that provides coverage for maternity services.

Preferred Drug Products

Information for the Patient:

The best way to reduce the cost of prescription drugs for both yourself and the plan is through the use of generic drugs. Generic medications are sold under unfamiliar names, yet by law they must have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength, and purity as their brand-name counterparts. Generic drugs usually cost less because their price doesn't include research and advertising costs. When you purchase covered generic drugs, you pay the lowest out-of-pocket amount and help keep prescription drug costs under control. Please encourage your physician to prescribe generic drugs whenever possible.

The WPS Preferred Drug Product list is designed to provide you with high quality prescription drug therapy while reducing costs. For those instances when a generic drug is not available, there are usually a number of similar brand-name drugs available to treat a particular health condition or illness. Although certain drugs are considered interchangeable for treating a particular health condition or illness, the costs charged by drug manufacturers and pharmacies can vary dramatically. The WPS Preferred Drug Product list, also called a "formulary," identifies the most cost-effective drugs by therapeutic category. Please show this list to your physician when he/she is prescribing medication for you. Together, you can decide on the best medication for you.

Important: Some products included on this list may not be covered under your plan. Please refer to your plan document or contact Member Services at the toll-free telephone number listed on your ID card.

Administered by:

Medco Managed Care, L.L.C.

P.O. Box 2026

Pine Brook, NJ 07058

Telephone: 1-800-818-0107

Welcome To The Medco Health
PAID Prescriptions National Pharmacy Network

We want to make using your prescription drug benefits easy. That's why we included:

- Questions and answers about our national pharmacy network.
- A web site to help you locate preferred pharmacies and help you learn more about Medco Health.
- A toll-free member services phone number.
- A list of preferred pharmacies where your drug card is welcomed and may be used.

Questions and Answers

How do I use PAID Prescriptions, L.L.C. Pharmacies?

Ordering new or refill prescriptions is easy:

- Simply present your identification card, featuring the Medco Health logo, when giving your prescription(s) to the pharmacist.
- Ask your pharmacist for a generic equivalent of your prescription if your doctor didn't indicate it. You can save money by purchasing generic drugs.
- The pharmacist will file your prescription claim electronically with Medco Health. Within minutes their computerized system will confirm your eligibility benefits.
- Your pharmacist will collect any amount that is your responsibility per your drug benefit.

What's the difference between generic and brand-name prescription drugs?

The brand name of a drug is the product name under which the drug is advertised and sold. Generic medications are sold under unfamiliar names, yet by law they must have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength, and purity as their brand-name counterparts. When you purchase covered generic drugs, you pay the lowest out-of-pocket amount and help keep prescription drug costs under control.

How do I find a preferred pharmacy?

PAID Prescriptions, L.L.C. offers an expansive network of participating pharmacies. PAID Prescriptions includes over 60,000 pharmacy locations nationwide. To locate the pharmacy nearest you, visit Medco Health's web site at *www.medcohealth.com.* Or contact Medco Health Member Services at 1-800-818-0107.

What if I use a pharmacy that doesn't participate in the PAID Prescriptions network?

Medco Health allows pharmacies that aren't currently participating in the PAID Prescriptions network to submit claims electronically. Ask your pharmacist to contact Medco Health at 1-800-922-1557 for information on how to transmit claims to them. Once Medco Health receives a claim, a Participating Pharmacy Agreement is automatically sent to the pharmacy.

If the pharmacy can't submit claims electronically to Medco Health, you'll need to pay in full when you receive your medication. Then, submit a completed claim to Medco Health for reimbursement. Your prescription receipt, indicating the date, store, prescription dispensed (including drug type, strength, dosage), dollar amount, and your identification number, must be attached to the claim form.

How can I save money on my prescriptions?

Go Generic! Generic drugs are sold under unfamiliar names, yet by law they must have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength, and purity as their brand-name counterparts. Generic drugs usually cost less because their price doesn't include research and advertising costs.

When you need a new prescription, ask your doctor whether a generic equivalent can be substituted for the brand-name drug. If your doctor approves the substitution, the pharmacist will generally charge you a lesser amount for your prescription. Over several refills, the savings can really add up. If you're currently taking a brand-name prescription drug, ask you doctor if a generic drug would work as well. If so, you can start saving money with your next refill.

Medco Health
Participating Chains*
(Preferred Pharmacies)

The PAID Prescriptions network includes over 60,000 pharmacy locations nationwide. So, chances are you'll find a preferred pharmacy close to your home or place of work. To locate the pharmacy nearest you, visit Medco Health's Web site at *www.medcohealth.com*. Or contact Member Services at the toll-free telephone number listed on your ID card.

The following list contains a sampling of major chain pharmacies that participate in the Medco Health PAID Prescriptions national pharmacy network.

A
A&P
Abco Markets
Acme Pharmacy
Albertson's
Allscripts
American Drug Stores
Anchor Pharmacies
Arrow Prescription Center
Aurora Pharmacy

B
Bakers Supermarkets
Bartell Drug
Bel Air
Bi Lo
Bi-Mart
Big Bear Stores
Big V Supermarkets
Brookshire Brothers
Brookshire Grocery Co
Brown & Cole
Bruno's Supermarket
Bvnj Partnership

C
Carle Rx Express
Carr-Gottstein Foods
City Market
Community Distributors
Community Pharmacies
Concord Pharmacy Svcs
Copps
Costco Co
CVS

D
D&W Food Centers
Dahl's Food Markets
Dierbergs Family Mkts
Dillon Stores
Discount Drug Mart
Docs Drugs
Dominicks Finer Food
Drug Emporium
Duane Reade
Duluth Clinic Pharmacies

E
Eagle Food Centers
Eckerd

F
Fairview Hosp & Hlthcare
Farm Fresh
Farmer Jack
Fedco Pharmacies
Fleming Companies
Foodarama Supermarkets
Foodmart
Fred Meyer
Fred's
Friendly Hills Healthcare
Fruth
Frys Food & Drug Az
Furrs Supermarkets

G
Gavin Herbert
Gemmel Pharmacy Group
Genovese Drug Stores
Giant Eagle
Giant Food
Golub
Grand Union

H
H E B Grocery
Haggen/Top Food & Drug
Hannaford Bros
Happy Harry
Harco Drug
Harp's Food Stores
Hart Stores
Harvard Pilgrim Health Care
Healthpartners
Henry Ford Health System
Hi-School Pharmacy
Homeland Stores
Horizon Pharmacies
Hy-Vee Stores

I
Inserra Spmkts/Shoprite
Integrity Healthcare Svcs

K
K&B
K-Va-T Food Stores
Kelsey-Seybold
Kerr Drug
Keystone Pharmacies
King Soopers Pharmacy
Kinney Drugs
Kmart
Knight Drugs
Kohl's Group
Kroger

L
Lewis Drugs
Long Drug Stores

M
Marc Glassman
Marsh Drugs
Marshfield Clinic
Maxi Drug
Mays Drug Stores
Med-X

Medic Drug
Medicap Pharmacies
Mediserv
Medistat Pharmacies
Meijer
Metro/Shoppers Supermarke
Minyard Food Stores

N
Navarro Dscnt Phcys
Neighborcare Pharmacies

O
Osco Drug Stores

P
P & C Food Markets
Pamida Pharmacy
Pathmark Stores
Perry Drug Stores
Phar-Mor
Pharmerica
Planned Parenthood
Price Chopper/Hen House
Publix Super Markets

Q
Quality Food Centers
Quality Markets
Quick Chek Food Stores

R
Raleys Drugs
Randalls Food & Drug
Rite Aid
Riverside Division- Ronetco Supermarkets
Rosauers Supermarkets
Rotech Medical Corp
Rxd Pharmacies

S
Safeway
Save Mart Supermarkets
Schnuck Markets
Seaway
Shaws Supermarkets
Shopko Stores
Shoprite Supermarkets
Smith's Food & Drug Ctrs
Snyder Drug Stores
Snyders Drug Stores
Stop & Shop Supermark
Super D Drugs
Super Fresh Food
Supermarket Investors
Supervalu Pharmacies

T
Talbert Health Svcs Corp
Target Stores
Texas Drug Warehouse
Thriftway
Thrifty
Thrifty Jr Drug Stores
Thrifty White Stores
Times Supermarket
Tom Thumb Food & Pharmacy
Tops Markets
Twin Knolls Pharmacy

U
Ukrop's Super Markets
Usa Drug

V
Village Supermarkets
Vons Companies

W
Wakefern Food
Wal*Mart Pharmacy
Waldbaums
Walgreens
Wegmans Food Markets
Weis Markets
Winn Dixie Stores

Z
Zallie Supermarket

WPS Drug Preauthorization

Why do some drugs require preauthorization?

Preauthorization is a tool to ensure the appropriate use of certain drugs and allows us to determine if a drug meets the medical necessity requirements of your policy.

Why am I sometimes asked to use a different drug than my doctor prescribed?

If you go to the pharmacy to have your prescription filled before getting preauthorization for a drug that requires it, your pharmacist may tell you about alternative medications available that may be equally effective but don't require our preauthorization.

If this occurs you can:

- Contact, or ask your pharmacy to contact, your doctor to ask about changing the prescription to an alternative drug. If you and your doctor approve an alternative medication, the pharmacy can immediately fill the prescription.
- Contact, or ask your doctor to contact, our WPS Member Services Department to initiate preauthorization for the prescribed drug.

Drug preauthorization information may be mailed or faxed to:

WPS Preauthorization
P.O. Box 8190 Madison, WI 53708-8190
Fax: 608-226-4777

How soon will I know if my drug has been approved?

For some situations, we may be able to provide a coverage decision in as little as 48 hours. For all other cases, WPS will notify you and your doctor within 10 business days of receiving the required information. If we determine the drug isn't covered or medically necessary for your illness or injury, no benefits will be payable under your WPS policy for that drug. You always have the right to purchase the drug at full retail price and appeal our decision. Please see your WPS policy for procedures on how to file an appeal or grievance of our coverage decision.

What if my situation is an emergency and I need my prescription now?

You may purchase a small supply of the medication at full retail price and seek authorization after the fact. If the request is approved, you may submit for reimbursement subject to the terms and conditions of your plan.

If you have any questions about our drug preauthorization process, please contact your WPS Member Services Representative at the toll-free telephone number listed on your WPS ID card.

The following drugs require preauthorization: Revised 12/13/11

Note: This list is accurate as of the time of posting, however changes may happen throughout the year. If you have a question about a particular drug you do not see on the list, please contact WPS Member Services at the toll-free telephone number listed on your WPS ID card to ensure it does not require authorization.

MEDICATION BRAND NAME	Medication Generic Name	Medco Review 800-753-2851	WPS Medical Affairs Review	Comments
ABRAXANE	Paclitaxel, Protein Bound		X	
ACCOLATE	Zafirlukast	X		
ACCRETROPIN	Somatropin		X	
ACIPHEX	Rabeprazole	X		Required as of 1/1/12
ACTEMRA	Tocizilumab		X	
ACTHAR GEL	Corticotropin		X	
ACTIQ	Fentanyl Citrate	X		
ACTONEL	Residronate	X		Required as of 1/1/12
ACTONEL w/CALCIUM	Residronate/calcium	X		Required as of 1/1/12
ADCIRCA	Tadalfil		X	
ADDERALL/XR	Amphetamine/Dextroamphetamine		X	
ADVATE	Anti-Hemophilic Factor		X	
AFINITOR	Everolimus		X	
ALIMTA	Pemetrexed		X	
ALPHANATE	Anti-Hemophilic Factor		X	
ALSUMA	Sumatriptan injection	X		
AMBIEN CR	Zolpidem Tartrate ER	X		
AMEVIVE	Alefacept		X	
AMNESTEEM	Isotretinoin	X		
AMPYRA	Fampridine		X	
ANADROL	Oxymetholone	X		
ANDRODERM	Testosterone	X		
ANDROGEL	Testosterone	X		
ANDROID	Methyltestosterone	X		
ANDROXY	Fluoxymesterone	X		
ANTAGON	Ganirelix Acetate		X	
ARALAST	Alpha Proteinase Inhibitor		X	
ARANESP	Darbepoetin		X	
ARCALYST	Rilonacept		X	
AREDIA	Pamidronate Disodium		X	
ARRANON	Nelarabine		X	
ARTHROTEC	Diclofenac / Misoprostol	X		

MEDICATION BRAND NAME	Medication Generic Name	Medco Review 800-753-2851	WPS Medical Affairs Review	Comments
ARZERRA	Ofatumumab		X	
ASTEPRO	Azelastine	X		
ATACAND	Candesartan	X		
ATACAND HCT	Candesartan/HCTZ	X		
ATRALIN GEL	Tretinoin		X	Age 30 and over
AUTOPLEX-T	Anti-Inhibitor Coagulant		X	
AVALIDE	Irbesartan /HCTZ	X		
AVAPRO	Irbesartan	X		
AVASTIN	Bevacizumab - oncology use only		X	
AVITA	Tretinoin		X	Age 30 and over
AXERT	Almotriptan Malate	X		
AXIRON	Testosterone	X		
BAL	Dimercaprol		X	
BECONASE AQ	Beclomethasone nasal	X		Required as of 1/1/12
BENICAR	Olmesartan Medoxomil	X		
BENICAR HCT	Olmesartan/HCTZ	X		
BENLYSTA	Belimumab		X	
BERINERT	C1-esterase inhibitor		X	
BEXXAR	Tositumomab		X	
BIOCLATE	Anti-Hemophilic Factor		X	
BONIVA	Ibandronate	X (oral)	X (injection)	
BOTOX	Botulinum Toxin		X	
BRAVELLE	Urofollitropin		X	
CAMPATH	Alemtuzumab		X	
CAMPTOSAR	Irinotecan		X	
CARBAGLU	Carglumic Acid		X	
CAVERJECT	Alprostadil - Urogenital		X	
CELEBREX	Celecoxib	X		
CEREDASE	Alglucerase		X	
CEREZYME	Imiglucerase		X	
CERUBIDINE	Daunorubicin		X	
CETROTIDE	Cetrorelix		X	
CHOREX	Chorionic Gonadotropin		X	
CHORIONIC GONADOTROPIN	Gonadotropin		X	
CIMZIA	Certolizumab		X	
CINRYZE	C1-esterase inhibitor		X	
CLARAVIS	Isotretinoin	X		

MEDICATION BRAND NAME	Medication Generic Name	Medco Review 800-753-2851	WPS Medical Affairs Review	Comments
CLOMID	Clomiphene Citrate		X	
CONCERTA	Methylphenidate		X	Required as of 1/1/12
COPAXONE	Glatiramer Acetate		X	
CORIFACT	Factor VIII Concentrate		X	
CRINONE 8%	Progesterone		X	
CYMBALTA	Duloxetine Hcl	X		
DACOGEN	Decitabine		X	
DAYTRANA	Methylphenidate patch		X	
DECA-DURABOLIN	Nandrolone Decanoate		X	
DELATESTRYL	Testosterone		X	
DEPO-PROVERA	Medroxyprogesterone Acetate		X	
DEPO-TESTOSTERONE	Testosterone cypionate		X	
DESOXYN	Methamphetamine		X	
DEXEDRINE	Dextroamphetamine		X	
DEXILANT	Dexlansoprazole	X		Required as of 1/1/12
DIDRONEL	Etidronate		X	
DIFFERIN	Adapalene		X	Age 30 and over
DIOVAN	Valsartan	X		
DORYX	Doxycycline Delayed Release		X	
DYSPORT	Abobotulinum Toxin A		X	
EDARBI	Azilsartan	X		Required as of 1/1/12
Edetate Calcium Disodium	Edetate Calcium Disodium		X	
EGRIFTA	Tesamorelin		X	
ELIDEL	Pimecrolimus	X		
ELLENCE	Epirubicin		X	
ELOXATIN	Oxaliplatin		X	
ENBREL	Etanercept		X	
EPIDUO	Adapalene/benzoyl peroxide		X	
EPOGEN	Epoetin Alfa		X	
ERBITUX	Cetuximab		X	
ERWINASE	Asparaginase		X	
EYLEA	Aflibercept		X	
FABRAZYME	Agalsidase Beta		X	
FACTOR	Anti-Hemophilic Factor		X	
FACTOR 7A	Anti-Hemophilic Factor		X	
FACTOR 8	Anti-Hemophilic Factor		X	
FACTOR 9	Von Willebrand Factor Complex		X	

MEDICATION BRAND NAME	Medication Generic Name	Medco Review 800-753-2851	WPS Medical Affairs Review	Comments
FACTREL	Gonadorelin		X	
FASLODEX	Fulvestrant		X	
FEIBA	Anti-Inhibitor Coagulant		X	
FERTINEX	Urofollitropin		X	
FIRMAGON	Degarelix		X	
FLECTOR PATCH	Diclofenac patch	X		
FLOLAN	Epoprostenol Sodium		X	
FOCALIN/XR	Dexmethylphenidate		X	
FOLLISTIM	Follistim		X	
FOLOTYN	Pralatrexate		X	
FORTEO	Teriparatide		X	
FORTESTA	Testosterone	X		
FOSAMAX plus D	Alendronate/vitamin D	X		Required as of 1/1/12
FROVA	Frovatriptan Succinate	X		
FUZEON	Enfuvirtide		X	
GELNIQUE	Oxybutynin gel		X	
GEMZAR	Gemcitabine		X	
GENOTROPIN	Somatropin		X	
GEREF	Sermorelin Acetate		X	
GILENYA	Fingolimod		X	
GLASSIA	Alpha Proteinase Inhibitor		X	
GLEEVEC	Imatinib		X	
GONAL	Follitropin		X	
GROWTH HORMONE	Growth Hormone		X	
HALAVEN	Eribulin		X	
HELIXATE	Anti-Hemophilic Factor		X	
HEMOFIL	Anti-Hemophilic Factor		X	
HERCEPTIN	Trastuzumab		X	
HUMATE	Anti-Hemophilic Factor		X	
HUMATROPE	Somatropin		X	
HUMIRA	Adalimumab		X	
HYATE	Anti-Hemophilic Factor		X	
HYCAMTIN	Topotecan		X	
ILARIS	Canakinumab		X	
INCIVEK	Telaprevir		X	
INCRELEX	Mecasermin		X	
INSPRA	Eplerenone	X		

MEDICATION BRAND NAME	Medication Generic Name	Medco Review 800-753-2851	WPS Medical Affairs Review	Comments
IRESSA	Gefitinib		X	
ISTODAX	Romidepsin		X	
IXEMPRA	Ixabepilone		X	
JAKAFI	Ruxolitinib		X	
JEVTANA	Cabazitaxel		X	
KALBITOR	Ecallantide		X	
KERALAC	Urea		X	
KINERET	Anakinra		X	
KOATE	Anti-Hemophilic Factor		X	
KOGENATE	Anti-Hemophilic Factor		X	
KONYNE	Anti-Hemophilic Factor		X	
KONYNE HT	Anti-Hemophilic Factor		X	
KRYSTEXXA	Pegloticase		X	
LAMISIL	Terbinafine HCI		X	
LETAIRIS	Ambrisentan		X	
LEUKINE	Sargramostin		X	
LEXAPRO	Escitalopram Oxalate	X		
LUCENTIS	Ranibizumab		X	
LUMIZYME	Alglucosidase Alfa		X	
LUNESTA	Eszopiclone	X		
LUPRON	Leuprolide Acetate		X	
LUTREPULSE	Gonadorelin		X	
LUVERIS	Lutropin		X	
LUVOX	Fluvoxamine	X		
MAKENA	Hydroxyprogesterone caproate		X	
MAXALT	Rizatriptan Benzoate	X		
MENOPUR	Menotropins		X	
MERIDIA	Sibutramine		X	
METADATE CD/ER	Methylphenidate		X	
METHITEST	Methyltestosterone	X		
METHYLIN ER	Methylphenidate		X	
MICARDIS	Teimisartan	X		
MONARC	Anti-Hemophilic Factor		X	
MONOCLATE	Anti-Hemophilic Factor		X	
MOZOBIL	Plerixafor		X	
MUSE	Alprostadil - Suppository		X	
MYLOTARG	Gemtuzumab Ozogamicin		X	

MEDICATION BRAND NAME	Medication Generic Name	Medco Review 800-753-2851	WPS Medical Affairs Review	Comments
MYOBLOC	Rimabotulinum Toxin Type B		X	
NASACORT AQ	Triamcinolone nasal	X		Required as of 1/1/12
NEULASTA	Pegfilgrastim		X	
NEUMEGA	Oprelvekin		X	
NEUPOGEN	Filgrastim		X	
NEXAVAR	Sorafenib		X	
NORDITROPIN	Somatropin		X	
NOVANTRONE	Mitoxantrone		X	
NOVOSEVEN	Coagulation Factor VIIa		X	
NPLATE	Romiplostim		X	
NUTROPIN	Somatropin		X	
NUVIGIL	Armodafinil	X		
OFORTA	Fludarabine		X	
OMNARIS	Ciclesonide Nasal	X		Required as of 1/1/12
OMNITROPE	Somatropin		X	
ONTAK	Denileukin		X	
ORENCIA	Abatacept		X	
ORFADIN	Nitisinone		X	
OVIDREL	Chorionic Gonadotropin		X	
OXANDRIN	Oxandrolone		X	
OZURDEX	Dexamethasone intravitreal implant		X	
PENLAC	Ciclopirox	X		
PENNSAID	Diclofenac topical	X		
PERGONAL	Menotropins		X	
PHENTERMINE	Phentermine		X	
PLENAXIS	Abarelix		X	
PONSTEL	Mefenamic Acid	X		
PREGNYL	Chorionic Gonadotropin		X	
PRILOSEC PACKETS	Omeprazole packets	X		Required as of 1/1/12
PRISTIQ	Desvenlafaxine	X		
PROCHIEVE 8%	Progesterone		X	
PROCRIT	Epoetin Alfa		X	
PROFASI	Gonadotropin		X	
PROGESTERONE	Progesterone		X	
PROLASTIN	Alpha Proteinase Inhibitor		X	
PROLEUKIN	Aldesleukin		X	
PROLIA	Denosumab		X	

MEDICATION BRAND NAME	Medication Generic Name	Medco Review 800-753-2851	WPS Medical Affairs Review	Comments
PROMACTA	Eltrombopag		X	
PROMETRIUM	Progesterone		X	
PROTHAR	Anti-Hemophilic Factor		X	
PROTONIX SUSP	Pantoprazole suspension	X		Required as of 1/1/12
PROTOPIC	Tacrolimus	X		
PROTROPIN	Somatrem		X	
PROVENGE	Sipuleucel-T		X	
PROVIGIL	Modafinil	X		
RECLAST	Zoledronic Acid		X	
RECOMBINATE	Anti-Hemophilic Factor		X	
REFACTO	Anti-Hemophilic Factor		X	
RELENZA	Zanamivir	X		
RELISORM	Gonadorelin		X	
RELPAX	Eletriptan Hydrobromide	X		
REMICADE	Infliximab		X	
REMODULIN	Treprostinil		X	
RENOVA	Tretinoin		X	Age 30 and over
REPRONEX	Menotropins		X	
RESTASIS	Cyclosporine eye drops		X	
RETIN-A	Tretinoin		X	Age 30 and over
REVATIO	Sildenafil		X	
REVLIMID	Lenalidomide		X	
RHINOCORT AQUA	Budesonide Nasal	X		Required as of 1/1/12
RITALIN/LA	Methylphenidate		X	
RITUXAN	Rituximab		X	
ROZEREM	Ramelteon	X		
SAIZEN	Somatropin		X	
SEROPHENE	Clomiphene Citrate		X	
SEROSTIM	Somatropin		X	
SIMPONI	Golimumab		X	
SINGULAIR	Montelukast Sodium	X		
SOLIRIS	Eculizumab		X	
SOLODYN	Minocycline		X	
SOTRET	Isotretinoin	X		
SPORANOX	Itraconazole	X		
SPRYCEL	Dasatinib		X	
STADOL	Butorphanol Tartrate	X		

MEDICATION BRAND NAME	Medication Generic Name	Medco Review 800-753-2851	WPS Medical Affairs Review	Comments
STELARA	Ustekinumab		X	
STRATTERA	Atomoxetine		X	
STRIANT	Testosterone	X		
SUMAVEL	Sumatriptan injection	X		
SUPPRELIN LA	Histrelin		X	
SUTENT	Sunitinib		X	
SYNAGIS	Palivizumab		X	
TAMIFLU	Oseltamivir	X		
TARCEVA	Erlotinib HCI		X	
TASIGNA	Nilotinib		X	
TAXOL	Paclitaxel		X	
TAXOTERE	Docetaxel		X	
TAZORAC	Tazarotene		X	
TEMODAR	Temozolomide		X	
TENUATE	Diethylpropion HCI		X	
TESTIM	Testosterone	X		
TESTOPEL	Testosterone pellets		X	
TESTOSTERONE ENANTHATE	Testosterone Enanthate		X	
TESTOSTERONE PROPION	Testosterone propionate		X	
TESTRED	Methyltestosterone	X		
TEVETEN	Eprosartan	X		
TEVETEN HCT	Eprosartan/HCTZ	X		
TEV-TROPIN	Somatropin		X	
THALOMID	Thalidomide		X	
TORISEL	Temsirolimus		X	
TREANDA	Bendamustine Hydrochloride		X	
TRETIN-X	Tretinoin		X	Age 30 and over
TREXIMET	Sumatriptan/Naproxen Sodium	X		
TYKERB	Lapatinib		X	
TYSABRI	Natalizumb		X	
TYVASO	Treprostinil Inhalation Solution		X	
ULORIC	Febuxostat	X		
UROFOLLITROPIN	Gonadotropin		X	
VANTAS	Histrelin		X	
VECTIBIX	Panitumumab		X	
VELCADE	Bortezomib		X	

MEDICATION BRAND NAME	Medication Generic Name	Medco Review 800-753-2851	WPS Medical Affairs Review	Comments
VENTAVIS	Iloprost		X	
VERAMYST	Fluticasone nasal		X	Required as of 1/1/12
VICTRELI	Boceprevir		X	
VIDAZA	Azacitidine		X	
VIMOVO	Naproxen + Esomeprazole	X		
VINBLASTINE	Vinblastine		X	
VOLTAREN GEL	Diclofenac topical	X		
VOTRIENT	Pazopinib		X	
VPRIV	Velaglucerase Alfa		X	
VYVANSE	Lisdexamfetamine		X	
WILATE	Factor VIII		X	
XALKORI	Crizotinib		X	
XELODA	Capecitabine		X	
XENICAL	Orlistat		X	
XEOMIN	Incobotulinum toxin A		X	
XGEVA	Denosumab		X	
XIAFLEX	Collagenase Clostridium Hystolyticum		X	
XOLAIR	Omalizumab		X	
XYNTHA	Anti-Hemophilic Factor		X	
YERVOY	Ipilimumab		X	
ZEGERID PACKETS	Omeprazole/sodium bicarb	X		Required as of 1/1/12
ZELBORAF	Vemurafenib		X	
ZEMAIRA	Alpha Proteinase Inhibitor		X	
ZEVALIN	Ibritumomab Tiuxetan		X	
ZOLADEX	Goserelin Acetate		X	
ZOMETA	Zoledronic Acid		X	
ZOMIG	Zolmitriptan	X		
ZORBTIVE	Somatropin		X	
ZORTRESS	Everolimus			
ZYFLO	Zileutin	X		

Frequently Asked Questions about Preauthorizing Prescription Drugs

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We know it's frustrating to find out at the pharmacy that your prescption requires our preauthorization. We understand also that the preauthorization process can be a little confusing. That's why we created this *Frequently Asked Questions* sheet-to help you better understand the drug preauthorization process and avoid unnecessary hassles at the pharmacy.

Why do some drugs require preauthorization?

Rising prescription drug costs are a serious problem. While we can't stop drug costs from increasing, we can work together to help find affordable and reasonable solutions. Preauthorization is one way to help control how often the most costly drugs are perscribed. Preauthorization also helps us determine if a prescribed drug meets the medical necessity requirements of your WPS policy.

How can I find out which drugs require preauthorization?

Only a small percentage of drugs require preauthorization. There are three ways to find out which drugs require preauthorization:

- **Visit our WPS Web site at *www.wpsic.com*** and click on the Members section. It's a fast, easy way to access the most up-to-date drug preauthorization list and other on-line services.
- **Call our Member Services Department** at the toll-free number listed on your WPS ID card.
- **Check your Member Guide.** It contains a list of drugs requiring preauthorization as well as the list of preferred brand-name drugs. However, these lists may have changed since your Member Guide was printed, so it's always a good idea to check our Web site or contact Member Services Department to verify if the drug needs preauthorization.

How do I preauthorize a drug?

Contact (or ask your doctor to contact) Member Services Department to initiate preauthorization for the prescribed drug. Your doctor will need to supply us with the following information:

- Name of drug to be preauthorized and beginning usage date.
- Specific medical diagnosis and copies of the related clinical notes.
- Your weight and height(for weight-loss medications only).

For some situations, we may be able to provide a coverage decision in as little as 48 hours after receiving the required information. For all other cases, we will notify you and your doctor of our coverage decision within two weeks of receiving the required information. If we determine the drug isn't covered or medically necessary for your illness or injury, no benefits will be payable under the WPS policy for that drug. Of course, you always have the right to purchase the drug at the full retail price and appeal our decision. Please see your WPS policy for procedures on how to file an appeal or grievance of our coverage decision.

What if my situation is an emergency and I need my prescription now?

If your prescription is needed to treat a medical emergency, ask your pharmacist to contact Medco Health to get approval for up to a 5-day supply of the medication. You will, however, need to follow the preauthorization procedures (see the question "How do I preauthorize a drug" for details) for any additional supply of the medication.

Why am I sometimes asked to use a different drug than my doctor prescribed?

If you go to the pharmacy to have your prescription filled before getting our preauthorization for a drug that requires it, your pharmacist may tell you about alternative medications available that may be equally effective but don't require our preauthorization. If this occurs you can:

- **Contact (or ask your pharmacy to contact) your doctor** to ask about changing the prescription to an alternative drug. If you and your doctor agree to use an alternative medication, the pharmacy can immediately fill the prescription. If your doctor doesn't approve an alternative drug, he or she will need to supply us with information showing the medical reason for prescribing the drug (see the question "How do I preauthorize a drug" for details).
- **Contact (or ask your doctor to contact) WPS Member Services** to initiate preauthorization for the prescribed drug. Your doctor will need to supply us with information showing the medical reason for prescribing the drug (see the question "How do I preauthorize a drug" for details).

What if I'm already taking a drug that requires preauthorization?

If you're a new WPS Customer, you'll need to get our preauthorization for your medication to determine if it will be covered. If you're an existing WPS customer taking one of the medications on our preauthorization list and it's currently covered by WPS, you don't need to get our preauthorization to continue receiving benefits for that drug. You will, however, need to preauthorize any new drugs you receive that are on our preauthorization list.

Who determines which prescription drug I use and ultimately which co-pay I pay?

You and your doctor always have the final decision on which drug you use. However, you can control the amount of money you pay for prescription drugs by asking for generic or preferred brand-name drugs. Follow these steps to help ensure you get the best value when purchasing prescription drugs:

- **Talk to your doctor about the medication prescribed** and ask if it's a generic or brand name drug. If it's a brand-name drug, check your Member Guide to see if preferred brand-name alternatives are available. If it's a brand-name drug and an equivalent generic drug or preferred brand-name alternative is available, ask your doctor if the alternative medication is right for you.
- **Check to see if the prescribed medication requires preauthorization.** We know it's frustrating to find out at the pharmacy that your prescription requires our preauthorization. To avoid that hassle, be sure to check the list of drugs requiring preauthorization on our WPS Web site at *www.wpsic.com,* in your Member Guide, or by calling Member Services Department at the toll-free number listed on your WPS ID card before you visit the pharmacy.
- **Fill your prescription at participating PAID Prescriptions pharmacies.** As your prescription drug benefit program administrator, Medco Health and its retail affiliate, PAID Prescriptions, L.L.C., offers an expansive network of participating pharmacies. Most pharmacies throughout Wisconsin and many pharmacies across the nation participate in the PAID Prescriptions drug reimbursement program. Preferred pharmacies agree to accept the PAID Prescriptions benefit payment plus your co-pay and equivalent generic/brand-name cost difference, if applicable, as full payment for a covered drug. Trained professionals at these pharmacies can help answer your

prescription drug questions and help you get the best value. Plus, these pharmacies have an on-line computer link to PAID Prescriptions, so they can verify your benefits and file your claim electronically with Medco Health while they fill your prescription. Your WPS Member Guide contains information on locating participating pharmacies. You can also locate participating pharmacies by visiting Medco Health on the Internet at *www.medcohealth.com,* or by calling Medco Health Member Services at 1-800-818-0107.

- **Show your WPS ID card when filling your prescription.** This ensures your pharmacy has access to the most up-to-date benefit information for you.
- **Take your WPS Member Guide with you to your health care appointment.** Your Member Guide contains lists of brand-name drugs, possible alternatives to some of the more common brand-name drugs, and drugs requiring preauthorization. Use it whenever you're prescribed a medication to help guide you and your doctor toward the most cost-effective drugs.

If you have any questions about preauthorizing prescription drugs or any aspect of your contract, please contact Member services Department at the toll-free number listed on your ID Card.

Three Tier Prescription Drug Plan

Your plan has three different co-pay levels for prescription drugs: Generic drugs are the lowest co-pay level, Preferred Brand-name drugs are the mid-level of co-pay, and other Brand-name drugs are the highest level of co-pay.

The included drug lists can help you identify which category your prescription is in (generic, preferred brand-name, or other brand-name). Utilizing this information may reduce your out-of-pocket costs.

These prescription drug lists are subject to all the terms, conditions, and provisions of your WPS policy. Please read your policy carefully or, if you have group coverage, your Certificate of Insurance provides complete information regarding the prescription drug program.

Inclusion of any drug on these lists doesn't guarantee that WPS will pay benefits for the purchased drug. WPS can only make our final decision on coverage and/or payment, when we've received and reviewed the actual claim. Purchases at non-participating pharmacies, prior to receiving pre-authorization or brand-name purchases when a generic equivalent is available may result in higher out-of-pocket costs.

Important: These lists are subject to change at any time without advance notice to you. To verify which category your prescription is in (generic, preferred brand-name or other brand-name) call the Medco Health Member Services number listed on your ID card.

Frequently Asked Questions about the Three-tier Co-pay Prescription Drug Benefit

We understand the new three-level co-pay structure can be a little confusing. That's why we've created this *Frequently Asked Questions* sheet-to help you better understand your three-tier drug benefit.

How does the Three-tier Co-pay Prescription Drug Benefit work?

The three-tier benefit has three co-pay levels (generic, preferred brand-name, and all other brand-name drugs). You pay the lowest co-pay when purchasing generic drugs, intermediate co-pay for preferred brand-name drugs, and the highest co-pay for all other brand-name drugs. The new three-tier benefit also contains a cost incentive to encourage the purchase of FDA-approved equivalent generic drugs as well as a preauthorization requirement for certain drugs. *Important: for complete details about your co-pay prescription drug coverage, please read your WPS policy.*

What is a preferred brand-name drug?

Competing pharmaceutical companies often develop similar drugs designed to treat the same health condition or illness. Although many of these drugs are considered interchangeable for treating a particular health condition or illness, the cost charged by the drug manufacturers and pharmacies can vary dramatically. Medco Health, our prescription drug claims administrator, has compiled a list of comparable medications and identified the most cost-effective drugs. We refer to the most cost-effective medications as "preferred" brand-name drugs. You can find a list of preferred brand-name drugs in your Member Guide or by calling our Member Services Department at the toll-free telephone number list on your WPS ID Card.

What's the difference between generic and brand-name prescription drugs?

The chemical make-up of generic drugs is identical to their equivalent brand-name drugs. Both must meet the same strict federal FDA standards. Typically, generic drugs cost less because their price doesn't include research and advertising costs. When you purchase covered generic drugs, you pay the lowest out-of-pocket amount and help keep prescription drug costs under control.

How does the three-tier generic/brand-name cost incentive work?

Most pharmacists automatically substitute equivalent generic drugs for brand-name drugs when filling prescriptions. Generic drugs are considered by many medical experts to be equally effective, but less costly than their brand-name counterparts. For this reason, if you or your doctor request a brand-name drug when the FDA-approved equivalent generic drug is available, you must pay the cost difference in addition to the co-pay amount.

Who determines which prescription drug I use and ultimately which co-pay I pay?

You and your doctor always have the final decision on which drug you use. However, you can control the amount of money you pay for prescription drugs by asking for generic or preferred brand-name drugs. Follow these steps to help ensure you get the best value when purchasing prescription drugs:

- **Talk to your doctor about the medication prescribed** and ask if it's a generic or brand name drug. If it's a brand-name drug, check your Member Guide to see if the drug is a preferred brand-name drug or if preferred brand-name alternatives are available. If it's not a preferred brand-name drug and an equivalent generic drug or preferred brand-name alternative is available, ask your doctor if the alternative medication is right for you.
- **Fill your prescription at participating PAID Prescriptions pharmacies.** As your prescription drug benefit program administrator, Medco Health and its retail affiliate, PAID Prescriptions, L.L.C., offers an expansive network of participating pharmacies. Most pharmacies throughout Wisconsin and many pharmacies across the nation participate in the PAID Prescriptions drug reimbursement program. Preferred pharmacies agree to accept the PAID Prescriptions benefit payment plus your co-pay and equivalent generic/brand-name cost difference, if applicable, as full payment for a covered drug. Trained professionals at these pharmacies can help answer your prescription drug questions and help you get the best value. Plus, these pharmacies have an on-line computer link to PAID Prescriptions, so they can verify your benefits and file your claim electronically with Medco Health while they fill your prescription. Your WPS Member Guide contains information on locating participating pharmacies. You can also locate participating pharmacies by visiting Medco Health on the Internet at *www.medcohealth.com,* or by calling Medco Health Member Services at 1-800-818-0107.
- **Show your WPS ID card when filling your prescription.** This ensures your pharmacy has access to the most up-to-date benefit information for you.
- **Take your WPS Member Guide with you to your health care appointment.** Your Member Guide contains lists of preferred brand-name drugs, possible alternatives to some of the more common brand-name drugs. Use it whenever you're prescribed a medication to help guide you and your doctor toward the most cost-effective drugs.

Rx Selections™ Member Guide

medco AT THE HEART OF HEALTH

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If you have questions about your prescription drug benefit, visit www.medco.com or call Member Services

Medco Health manages your prescription drug benefit for your health plan.

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Rx Selections ™ is a formulary list of medications that may be covered under your prescription drug plan. This list was reviewed by an independent group of practicing doctors and pharmacists, and it contains medications made by most pharmaceutical manufacturers. It includes medications for many covered conditions.

SAVING MONEY ON PRESCRIPTIONS

Your plan may prefer some medications over others. These are called *preferred drugs.*

You may pay:

- **Lowest copayment/co-insurance for generic drugs**
- **Higher copayment/co-insurance for preferred brand-name drugs**
- **Highest copayment/co-insurance for nonpreferred, brand-name drugs**

Your doctor may be able to help you save money by prescribing generic and preferred brand-name drugs if appropriate. So be sure to bring this guide with you on every visit to your doctor. Some commonly prescribed nonpreferred drugs are also listed in this guide for your reference.

Please Note: This guide does not contain a complete list of preferred and nonpreferred drugs. It only lists the *most commonly prescribed drugs.* For an updated and complete listing of your prescription benefit, you can visit the "Benefit Highlights" section of our website-www.medco.com and click the View your preferred drug list link. Not all medications listed here are covered by every prescription drug plan.

FINDING MEDICATIONS WITH LOWER COPAYMENTS/CO-INSURANCE

This guide lists medications two ways to help you find some generic, preferred, and nonpreferred drugs.

Section I Alphabetically by Drug Category (such as Respiratory)

Within each category, medications are listed in alphabetical order with generic, preferred brand-name, and nonpreferred brand-name drugs sorted separately.

G	Means a preferred generic medication
PB	Means a preferred brand-name medication
B	Means a nonpreferred brand-name medication

Section II Alphabetically by Brand-Name

After each nonpreferred brand-name drug, you will find possible generic and preferred brand-name alternatives.

WPS PREFERRED DRUG LIST INFORMATION FOR YOUR PHYSICIAN

ANTI-INFECTIVES (Antibiotics/Antifungals)

Oral Antifungal Agents

G clotrimazole
G fluconazole
G griseofulvin
G griseofulvin ultramicrosize
G itraconazole
G ketoconazole
G nystatin
G terbinafine HCL
PB Ancobon
PB Lamisil Oral Granules
PB Noxafil
PB Sporanox Oral Solution
PB Vfend Tablet
B Diflucan
B Grifulvin
B Gris-Peg
B Lamisil Tablet
B Mycostatin
B Mycelex Troche
B Nizoral
B Sporanox Capsule
B Vfend Suspension

Oral Cephalosporins

G cefaclor
G cefadroxil hydrate
G cefdinir
G cefpodoxime proxetil
G cefprozil
G cefuroxime axetil
G cephalexin monohydrate
G cephradine
B Celcor CD
B Cedax
B Ceftin
B Cefzil
B Duricef
B Keflex
B Omnicef
B Raniclor
B Spectracef
B Suprax
B Vantin
B Velosef

Oral Penicillins

G amoxicillin trihydrate
G amoxicillin trihydrate/ potassium clavulanate
G ampicillin trihydrate
G dicloxacillin sodium
G penicillin v potassium
PB Augmentin Chewable Tablet 125 - 31.25 mg, 250 - 62.5mg
PB Augmentin Suspension 125-31.25mg/5, 250 - 62.5mg/5
PB Augmentin XR
B Augmentin Chewable Tablet 200 - 28.5mg, 400 - 57mg
B Augmentin ES
B Augmentin Suspension 200-28.5mg/5, 400 - 57mg/5
B Augmentin Tablet
B Dispermox
B Geocillan
B Moxatag

Oral Sulfas

G erythromycin ethylsuccinate/ sulfisoxazole acetyl
G sulfadiazine
G sulfamethoxazole/ trimethoprim
G sulfisoxazole
B Bactrim DS
B Gantrisin
B Septra DS

Oral Tetracyclines

G doxycycline hyclate capsule
G doxycycline hyclate tablet
G doxycycline monohydrate
G minocycline HCl
G tetracycline HCl
PB Adoxa
PB Oracea
B Doryx
B Dynacin
B Minocin
B Monodox
B Periostat
B Solodyn
B Vibramycin

Oral Erythromycins

G azithromycin
G clarithromycin
G clarithromycin ER
G erythromycin base
G erythromycin ethylsuccinate
G erythromycin ethylsuccinate/ sulfisoxazole acetyl
G erythromycin stearate
B Biaxin
B Biaxin XL
B EryPed
B PCE
B Zithromax
B Zmax

Oral Quinolones

G ciprofloxacin HCl tablet
G ofloxacin
PB Cipro Suspension
PB Levaquin
PB Noroxin
B Avelox
B Cipro Tablet
B Cipro XR
B Factive
B Floxin
B Proquin XR
B Tequin

Oral Urinary Tract Agents

G methenamine hippurate
G methenamine mandelate
G nitrofurantoin
G nitrofurantoin macrocrystal
G phenazopyridine HCL
G trimethoprim
PB Furadantin
B Hiprex
B Macrobid
B Macrodantin
B Monurol
B Primsol

Oral Misc. Agents

G clindamycin HCl
G neomycin sulfate
PB Dapsone
PB Tobi Ampul for Nebulization
PB Zyvox
B Cleocin HCl
B Ketek
B Xifaxan

Vaginal Antifungals

G fluconazole
G miconazole nitrate vaginal suppository
G nystatin
G terconazole
PB Gynazole-I
B Terazol

G.I. (Ulcer)

Ulcer Drugs

G cimetidine HCl liquid
G cimetidine tablet
G famotidine
G misoprostol
G nizatidine
G omeprazole
G pantoprazole sodium
G ranitidine HCl

PB Axid Oral Solution
PB Nexium
B Aciphex
B Axid Capsule
B Cytotec
B Pepcid
B Prevacid
B Prilosec Rx
B Protonix

B Tagamet
B Zantac Rx
B Zegerid

Other G.I. Drugs

G sucralfate tablet
PB Carafate Suspension
PB Pylera
B Carafate Tablet

CARDIOVASCULAR (Blood Pressure/Heart/Cholesterol)

ACE Inhibitors

G benazepril HCl
G captopril
G enalapril maleate
G fosinopril sodium
G lisinopril
G moexipril
G quinapril
G ramipril
G trandolapril
PB Aceon
PB Altace
B Accupril
B Capoten
B Lotensin
B Mavik
B Monopril
B Prinivil
B Univasc
B Vasotec
B Zestril

Antilipidemics

G cholestyramine/aspartame
G cholestyramine/sucrose
G colestipol HCL
G fenofibrate, micronized
G gemfibrozil
G lovastatin
G niacin
G pravastatin
G simvastatin
PB Advicor
PB Altoprev
PB Crestor
PB Fenoglide
PB Lipitor
PB Lovaza
PB Niaspan
PB Simcor
PB Tricor
PB Triglide
PB Vytorin
PB Welchol
PB Zetia
B Antara
B Caduet
B Colestid
B Lescol
B Lescol XL
B Lofibra
B Lopid
B Mevacor
B Pravachol
B Questran
B Questran Light
B Zocor

Angiotensin II Blockers & Renin Inhibitors

PB Atacand
PB Atacand HCT
PB Benicar
PB Benicar HCT
PB Cozaar
PB Diovan
PB Diovan HCT
PB Hyzaar
PB Micardis
PB Micardis HCT
PB Tekturna
PB Tekturna HCT
B Avalide
B Avapro
B Teveten
B Teveten HCT

Beta Blockers

G acebutolol HCl
G atenolol
G betaxolol HCl
G bisoprolol fumarate
G carvedilol
G labetalol HCl
G metoprolol succinate
G metoprolol tartrate
G nadolol
G pindolol
G propranolol HCl
G propranolol HCl, capsule, sustained action 24 hr
G timolol maleate
PB Coreg CR
B Bystolic
B Coreg
B Corgard
B Inderal
B Inderal LA
B Innopran XL
B Kerlone
B Levatol
B Lopressor
B Normodyne
B Sectral
B Tenormin
B Toprol XL
B Trandate
B Zebeta

Calcium Blockers

G diltiazem HCl
G diltiazem HCl capsule sustained release 12 hr
G diltiazem HCl capsule sustained release 24 hr
G nimodipine
G verapamil HCl
G verapamil HCl capsule, 24 hr sustained release
G verapamil HCl tablet, sustained action
PB Cardizem LA
B Calan SR
B Cardizem
B Cardizem CD
B Cardizem SR
B Covera-HS
B Isoptin S.R.
B Nimotop
B Tiazac
B Verelan
B Verelan PM

Dihydropyridines

G amlodipine besylate
G felodipine
G isradipine
G nifedipine
G nifedipine tablet, sustained release
G nisoldipine
PB Sular
B Adalat CC
B Cardene SR
B DynaCirc
B DynaCirc CR
B Norvasc
B Plendil
B Procardia XL

Nitroglycerin Patches

G nitroglycerin patch
PB Minitran Patch
B Nitro-Dur Patch

CARDIOVASCULAR (Blood Pressure/Heart/Cholesterol)

Adrenergic Antagonists
<u>& Related Drugs</u>

G clonidine HCl
G doxazosin mesylate
G guanfacine HCl
G methyldopa
G prazosin HCl
G reserpine
G terazosin HCl
PB Catapres-TTS Patch
B Cardura
B Cardura XL
B Catapres
B Hytrin
B Minipress
B Tenex

<u>Combination Antihypertesives</u>

G amlodipine besylate/benazepril
G atenolol/chlorthalidone
G benazepril HCl/ hydrochlorothiazide
G bisoprolol fumarate/ hydrochlorothiazide
G captopril/hydrochlorothiazide
G enalapril maleate/ hydrochlorothiazide
G fosinopril/hydrochlorothiazide
G hydralazine HCl/ hydrochlorothiazide
G lisinopril/hydrochlorothiazide
G methyldopa/hydrochlorothiazide
G metoprolol/hydrochlorothiazide
G moexipril/ hydrochlorothiazide
G propranolol HCl/ hydrochlorothiazide
G quinapril/ hydrochlorothiazide
PB Exforge
PB Lotrel 5-40mg,10-40mg
B Accuretic
B Azor
B Capozide
B Clorpres
B Corzide
B Lexxel
B Lopressor HCT
B Lotensin HCT
B Lotrel 2.5-10mg, 5-10mg, 5-20mg, 10-20mg
B Monopril HCT
B Prinzide
B Tarka
B Tenoretic
B Uniretic
B Vaseretic
B Zestoretic
B Ziac

ENDOCRINE (Diabetes/Hormones/Contraceptives)

Insulin Therapy

PB Apidra
PB Apidra Solostar
PB Humalog
PB Humalog, Mix 50/50
PB Humalog, Mix 75/25
PB Humulin
PB Lantus
PB Lantus SoloStar
PB Levemir
PB NovoLog
PB NovoLog Mix 70/30
B Novolin

Non-Insulin Hypoglycemic Agents

G acarbose
G chlorpropamide
G glimepiride
G glipizide
G glipizide/metformin HCl
G glyburide
G glyburide/metformin HCl
G glyburide, micronized
G metformin HCl
G metformin HCl tablet, sustained release 24 hr
G tolazamide
G tolbutamide
PB Actoplus Met
PB Actos
PB Avandamet
PB Avandaryl
PB Avandia
PB Byetta
PB Duetact
PB Janumet
PB Januvia
PB Prandin
PB Starlix
PB Symlin
B Amaryl
B DiaBeta
B Fortamet
B Glucophage
B Glucophage XR
B Glucotrol
B Glucotrol XL
B Glucovance
B Glynase
B Glyset
B Metaglip
B Micronase
B Prandimet
B Precose
B Riomet
B Tolinase

Estrogens/Estrogen Combinations

G estradiol patch
G estradiol tablet
G estradiol/norethindrone acetate
G estropipate
G methyltestosterone/ estrogens, esterified
PB Activella 0.5-0.1mg
PB Cenestin
PB Climara Patch
PB Combipatch
PB Divigel
PB Enjuvia
PB Estraderm Patch
PB Estratest
PB Estratest H.S.
PB Estring
PB Evamist
PB Premarin Tablet
PB Premarin Vaginal Cream
PB Premphase
PB Prempro
PB Vagifem
PB Vivelle
PB Vivelle Dot
B Activella 1-0.5 mg
B Alora
B Angeliq
B Climara Pro Patch
B Elestrin
B Estrace
B Estrasorb
B Estrogel
B Femhrt
B Femring
B Femtrace
B Menest
B Menostar
B Ogen
B Ortho-Prefest

Contraceptives Agents

G desogestrel-ethinyl estradiol
G desogestrel-ethinyl estradiol/ethinyl estradiol
G ethinyl estradiol/ drospirenone
G ethynodiol d-ethinyl estradiol
G levonorgestrel-ethinyl estradiol
G norethindrone
G norethindrone a-e estradiol
G norethindrone a-e estradiol/ferrous fumarate
G norethindrone-ethinyl estradiol
G norethindrone-mestranol
G norgestimate-ethinyl estradiol
G norgestrel-ethinyl estradiol
PB Cyclessa
PB Lybrel
PB NuvaRing
PB Ortho Tri-Cyclen Lo
PB Plan B
PB Seasonique
PB Yaz
B Alesse
B Brevicon
B Demulen
B Desogen
B Estrostep Fe
B Levlen
B Levlite
B Loestrin
B Loestrin Fe
B Loestrin 24 Fe
B Lo/Ovral
B LoSeasonique
B Mircette
B Modicon
B Nordette
B Norinyl
B Ortho-Cept
B Ortho-Cyclen
B Ortho Evra
B Ortho Micronor
B Ortho-Novum
B Ortho Tri-Cyclen
B Ovcon
B Ovral
B Seasonale
B Tri-Levlen
B Tri-Norinyl
B Triphasil
B Yasmin

ENDOCRINE (Diabetes/Hormones/Contraceptives)		
<u>Blood Glucose Test Strips</u> **G** alcohol antiseptic pads **PB** Accu-Chek Active Test Strips **PB** Accu-Chek Aviva Test Strips	**PB** Accu-Chek Comfort Curve Test Strips **PB** Accu-Chek Compact Test Strips **PB** Fast Take Test Strips	**PB** One Touch Test Strips **PB** One Touch Ultra Test Strips **PB** Surestep Pro Test Strips **PB** Surestep Test Strips

PSYCHOTHERAPEUTICS (Anxiety/Depression)

Tricyclic Antidepressants

G amitriptyline HCl
G amoxapine
G clomipramine HCl
G desipramine HCl
G doxepin HCl
G imipramine HCl
G nortriptyline HCl
G protriptyline HCL
G trimipramine maleate
PB Tofranil PM
B Anafranil
B Asendin
B Aventyl HCl
B Elavil
B Norpramin
B Pamelor
B Sinequan
B Surmontil
B Tofranil
B Vivactil

Miscellaneous Antidepressants

G bupropion HCl tablet
G bupropion HCl tablet, sustained action
G maprotiline HCl
G mirtazapine
G trazodone HCl
G venlafaxine HCl
PB Cymbalta
PB Effexor XR
PB Pristiq
B Desyrel
B Effexor
B Ludiomil
B Remeron
B Serzone
B Wellbutrin
B Wellbutrin SR
B Wellbutrin XL

SSRI Antidepressants

G citalopram HBR
G fluoxetine HCl
G fluvoxamine maleate
G paroxetine HCl tablet
G sertraline HCl
B Celexa
B Lexapro
B Luvox
B Luvox CR
B Paxil
B Paxil CR
B Pexeva
B Prozac
B Prozac Weekly
B Sarafem
B Zoloft

MAOI Antidepressants

G tranylcypromine sulfate
PB Nardil
B Emsam
B Parnate

Anxiolytics

G alprazolam
G alprazolam XR
G buspirone HCl
G chlordiazepoxide HCl
G clorazepate dipotassium
G diazepam
G lorazepam
G oxazepam
B Ativan
B Buspar
B Librium
B Niravam
B Paxipam
B Serax
B Tranxene SD
B Tranxene T-Tab
B Valium
B Xanax
B Xanax XR

Antipsychotics

G chlorpromazine HCl
G clozapine
G fluphenazine HCl
G haloperidol
G haloperidol lactate concentrate, oral
G loxapine succinate
G perphenazine
G risperidone
G thiothixene
G thiothixene HCl
G trifluoperazine HCl
PB Clozaril
PB Geodon
PB Moban
PB Orap
PB Seroquel
PB Seroquel XR
PB Zyprexa
PB Zyprexa Zydis
B Abilify
B Invega
B Risperdal
B Symbyax

Hypnotic Agents

G chloral hydrate
G estazolam
G flurazepam HCl
G temazepam
G triazolam
G zaleplon
G zolpidem tartrate
PB Ambien CR
PB Restoril 7.5 mg, 22.5mg
B Ambien
B Dalmane
B Doral
B Halcion
B Lunesta
B ProSom
B Restoril 15 mg, 30 mg
B Rozerem
B Sonata

NSAIDs (Pain Relievers)		
<u>NSAIDs</u> **G** etodolac **G** etodolac tablet, sustained release 24hr **G** flurbiprofen **G** ibuprofen **G** indomethacin **G** indomethacin capsule, sustained action **G** ketoprofen **G** ketoprofen capsule, 24 hr sustained release pellets **G** meclofenamate sodium **G** meloxicam **G** nabumetone **G** naproxen	**G** naproxen sodium **G** naproxen sodium tablet, sustained action **G** oxaprozin **G** piroxicam **G** sulindac **G** tolmetin sodium **B** Anaprox DS **B** Ansaid **B** Arthrotec **B** Clinoril **B** Daypro **B** diclofenac potassium **B** diclofenac sodium **B** EC-Naprosyn **B** Feldene	**B** Flector **B** Indocin **B** Lodine **B** Lodine XL **B** Mobic **B** Motrin **B** Naprelan **B** Naprosyn **B** Oruvail **B** Relafen **B** Toradol **B** Voltaren **B** Voltaren-XR **<u>NSAID COX-2 Inhibitors</u>** **PB** Celebrex

RESPIRATORY (Allergy/Asthma)

Antihistamines

G clemastine fumarate
G cyproheptadine HCl
G dexchlorpheniramine maleate syrup
G diphenhydramine HCl 50mg
G fexofenadine HCl
G hydroxyzine HCl
G hydroxyzine pamoate
G promethazine HCL
PB Allegra Oral Suspension
PB Clarinex
B Allegra ODT
B Allegra
B Atarax
B Vistaril
B Xyzal

Antihistamines/ Decongestant Combinations

G carbetapentane tannate/ chlorpheniramine tannate
G carbetapentane tannate/ ephedrine tannate/phenylephrine/ chlorpheniramine suspension
G carbetapentane tannate/ phenylephrine tannate/ chlorpheniramine suspension
G phenylephrine HCl/ phenyltoloxamine citrate/ chlorpheniramine
G phenylephrine HCl/ promethazine HCl
G phenylephrine tannate/ chlorpheniramine tannate
G phenylephrine tannate/ diphenhydramine tannate suspension
G phenylephrine tannate/ pyrilamine tannate
G phenylephrine tannate/ pyrilamine tannate/ chlorpheniramine
G pseudoephedrine HCl/ brompheniramine maleate
G pseudoephedrine HCl/ chlorpheniramine maleate capsule, sustained release 12 hr
G pseudoephedrine tannate/ chlorpheniramine tannate
G pseudoephedrine tannate/ dexchlorpheniramine tannate
PB Allegra-D 12 Hour
PB Allegra-D 24 Hour
PB Clarinex D 12 hr
PB Clarinex D 24 hr
PB Deconamine Liquid
PB Deconamine SR
B Deconamine Tablet
B Rynatan
B Rynatuss
B Semprex-D

Misc. Pulmonary Agents

G acetylcysteine
G cromolyn sodium ampul for nebulization
G ipratropium/ albuterol sulfate
G ipratropium bromide solution
PB Advair Diskus
PB Advair HFA
PB Atrovent HFA
PB Cinryze
PB Combivent
PB Intal Inhaler
PB Letairis
PB Pulmozyme
PB Revatio
PB Singulair
PB Spiriva
PB Symbicort
PB Tilade
PB Tracleer
PB Ventavis
B Accolate
B Atrovent Inhalation Solution
B Duoneb
B Xolair
B Zyflo
B Zyflo CR

Beta Agonists Oral

G albuterol sulfate
G albuterol sulfate SR
G metaproterenol sulfate
G terbutaline sulfate
B Alupent
B Brethine
B Proventil
B Ventolin
B Volmax

Beta Agonist Inhalers

G albuterol
G albuterol sulfate
G isoetharine HCl solution
G metaproterenol sulfate solution
PB Foradil
PB Maxair Autohaler
PB Perforomist
PB Proair HFA
PB Serevent Diskus
PB Xopenex
PB Xopenex HFA
B Accuneb
B Alupent
B Brovana
B Proventil HFA
B Ventolin HFA

Nasal Corticosteriods

G flunisolide
G fluticasone propionate
PB Nasacort AQ
PB Nasonex
PB Rhinocort Aqua
PB Veramyst
B Beconase AQ
B Flonase
B Nasacort
B Nasalide
B Nararel
B Omnaris

Inhaled Steriods

PB Asmanex
PB Flovent Diskus
PB Flovent HFA
PB Pulmicort Flexhaler
PB Pulmicort Inhaler
PB Pulmicort Respules
PB QVAR
B Aerobid
B Aerobid-M
B Alvesco
B Azmacort

OSTEOPOROSIS/PAGET'S DISEASE

G alendronate sodium	**PB** Forteo	**B** Actonel 75 mg
G calcitonin, salmon, synthetic	**PB** Fosamax Plus D	**B** Actonel 150 mg
PB Actonel 30 mg	**PB** Fosamax Solution	**B** Actonel with Calcium
PB Boniva	**B** Actonel 5 mg	**B** Fosamax Tablet
PB Evista	**B** Actonel 35 mg	**B** Miacalcin Nasal Spray

MIIGRANE/HEADACHE THERAPY

G acetaminophen/butalbital	**G** sumatriptan succinate	**PB** Relpax
G acetaminophen/caffeine/ butalbital	**PB** Amerge	**PB** Zomig
	PB Ergomar	**PB** Zomig ZMT
G aspirin/caffeine/butalbital	**PB** Frova	**B** Axert
G dihydroergotamine mesylate	**PB** Maxalt	**B** Cafergot Tablet
G ergotamine/caffeine	**PB** Maxalt MLT	**B** Imitrex
G isometheptene mucate/ acetaminophen/ dichloralphenazone	**PB** Phrenilin	**B** Midrin
	PB Phrenilin Forte	**B** Migranal
		B Treximet

DRUGS TO TREAT ALZHEIMER'S DISEASE

G galantamine HBr	**PB** Exelon	**B** Namenda
PB Aricept	**PB** Razadyne Oral Solution	**B** Razadyne ER
PB Aricept ODT	**B** Cognex	**B** Razadyne Tablet

DRUGS TO TREAT OVERACTIVE BLADDER

G flavoxate	**PB** Enablex	**B** Ditropan
G oxybutynin chloride	**PB** Oxytrol	**B** Ditropan XL
PB Detrol	**PB** Sanctura XR	**B** Sanctura
PB Detrol LA	**PB** Vesicare	**B** Toviaz

LIST OF BRAND-NAME DRUGS AND THEIR POSSIBLE PREFERRED BRAND-NAME OR GENERIC ALTERNATIVES

Brand-Name Drug	Alternative
Abilify®	clozapine (generic), risperidone (generic), Geodon ® (Pfizer), Seroquel ® (AstraZeneca), Seroquel XR ® (AstraZeneca), Zyprexa ® (Eli Lilly)
Accolate®	Singulair® (Merck)
Accuneb®	albuteraol sulfate (generic)
Accupril®	quinapril (generic)
Accuretic®	quinapril/hydrochlorothiazide (generic)
Aciphex®	omeprazole (generic), Nexium® (AstraZeneca)
Activella 1-0.5mg®	estradiol/norethindrone acetate (generic)
Actonel 5mg®	alendronate sodium 5mg (generic), alendronate sodium 10mg (generic), Boniva® (Roche)
Actonel 35mg®, 75mg, 150mg	alendronate sodium 35mg (generic), alendronate sodium 70mg (generic), Boniva® (Roche)
Actonel with Calcium®	alendronate sodium (generic), Boniva® (Roche)
Adalat® CC	nifedipine ER (generic), amlodipine besylate (generic), Sular® (First-Horizon)
Aerobid®	Asmanex® (Schering), Flovent Inhaler® (Glaxo SmithKline), Pulmicort Inhaler® (AstraZeneca), QVAR® (Ivax)
Aerobid-M®	Asmanex® (Schering), Flovent Inhaler® (Glaxo SmithKline), Pulmicort Inhaler® (AstraZeneca), QVAR® (Ivax)
Allegra® ODT	fexofenadine HCL (generic)
Allegra ®Tablet	fexofenadine HCl (generic), Clarinex® (Schering)
Alesse®	Aviane® (Barr-branded generic), Lessina® (Barr-branded generic), Lutera® (Watson-branded generic), Lybrel® (Wyeth)
Alora®	estradiol patch (generic), Climara® (Berlex), Estraderm® (Novartis), Vivelle® (Novartis)
Alupent ®	metaproterenol sulfate (generic), Maxair Autohaler® (Graceway), Proair HFA® (Teva), Xopenex HFA® (Sepracor)
Alvesco®	Asmanex® (Schering), Flovent HFA® (GlaxoSmithKline), Pulmicort Flexhaler® (AstraZeneca)
Amaryl®	glimepiride (generic)
Ambien®	zolpidem tartrate (generic)
Amoxil®	amoxicillin trihydrate (generic)
Anafranil®	clomipramine HCl (generic)
Anaprox DS®	naproxen sodium (generic)
Angeliq®	estradiol/norethindrone acetate (generic), Activella® 0.5-0.1mg (Novo Nordisk), Premphase® (Wyeth), Prempro® (Wyeth)
Ansaid®	flurbiprofen (generic)
Antara®	fenofibrate (generic), gemfibrozil (generic), Tricor® (Abbott), Triglide® (Sciele)
Arthrotec®	ibuprofen (generic), naproxen(generic), Celebrex® (Pfizer)

Brand-Name Drug	Alternative
Asendin®	amoxapine (generic)
Atarax®	hydroxyzine HCl (generic)
Ativan®	lorazepam (generic)
Atrovent® solution	ipratropium bromide (generic)
Augmentin® chewable tablet 200-28.5mg, 400-57mg	amoxicillin trihydrate/potassium clavulanate (generic)
Augmentin® suspension 200-28.5mg, 400-57mg/5	amoxicillin trihydrate/potassium clavulanate (generic)
Augmentin®tablet	amoxicillin trihydrate/potassium clavulanate (generic)
Augmentin ES®	amoxicillin trihydrate/potassium clavulanate (generic)
Avalide®	Atacand HCT® (AstraZeneca), Benicar HCT® (Daiichi Sankyo), Diovan HCT® (Novartis), Hyzaar® (Merck) , Mircadis HCT® (BIPI)
Avapro®	Atacand® (AstraZeneca), Benicar® (Daiichi Sankyo), Cozaar® (Merck), Diovan® (Novartis), Mircadis® (BIPI)
Avelox®	Levaquin® (J&J)
Aventyl HCl®	nortriptyline HCl (generic)
Axert®	Amerge® (GlaxoSmithKline), Frova® (Endo), Imitrex® (GlaxoSmithKline), Maxalt® (Merck), Relpax® (Pfizer), Zomig® (AstraZeneca)
Axid®Capsule	nizatidine (generic)
Azmacort®	Asmanex® (Schering), Flovent Inhaler® (GlaxoSmithKline), Pulmicort Inhaler® (AstraZeneca), QVAR® (Ivax)
Azor®	amoldipine besylate (generic), Benicar® (Daiichi Sankyo)
Bactrim DS®	sulfamethoxazole/trimethoprim (generic)
Beconase AQ®	flunisolide (generic), fluticasone propionate (generic), Nasacort AQ® (Aventis), Nasonex® (Schering), Rhinocort Aqua® (AstraZeneca)
Biaxan®	clarithromycin (generic)
Biaxan XL®	clarithromycin ER (generic)
Biohist-LA®	pseudoephedrine HCl/clorpheniramine maleate (generic)
Brethine®	terbutaline sulfate (generic)
Brevicon®	Necon® (Watson-branded generic), Nortrel® (Barr-branded generic)
Brovana®	Foradil® (Schering), Proair HFA® (Teva), Serevent Diskus® (GlaxoSmithKline)
Buspar®	buspirone HCl (generic)
Butisol Sodium®	chloral hydrate (generic), temazepam (generic), triazolam (generic)
Bystolic®	atenolol (generic), metoprolol tartrate (generic)
Caduet®	amlodipine besylate (generic), Lipitor® (Pfizer)
Calan SR®	verapamil HCl tablet, sustained action (generic)
Capoten®	captopril (generic)
Capozide®	captopril/hydrochlorothiazide (generic)
Carafate Tablet®	sucralfate (generic)
Cardene SR®	amlodipine besylate (generic), nifedipine ER (generic), Sular®(First-Horizon)
Cardizem ®	diltiazem HCl (generic)

Brand-Name Drug	Alternative
Cardizem CD®	diltiazem HCl capsule, sustained release 24 hr (generic)
Cardizem SR®	diltiazem HCl capsule, sustained release 12 hr (generic)
Cardura®	doxazosin mesylate (generic)
Cataflam®	etololac (generic), ibuprofen (generic), naproxen (generic)
Catapres®	clonidine HCl (generic)
Ceclor CD®	cefaclor (generic), cefdinir (generic), cefuroxime axetil (generic)
Cedax®	cefaclor (generic), cefdinir (generic), cefuroxime axetil (generic)
Ceftin®Suspension	cefuroxime axetil (generic)
Ceftin® Tablet 250mg, 500mg	cefuroxime axetil (generic)
Cefzil®	cefaclor (generic), cefdinir (generic), cefuroxime axetil (generic)
Celexa®	citalopram (generic)
Cipro Tablet®	ciprofloxacin HCl tablet (generic)
Cleocin HCl®	clindamycin HCl (generic)
Climara Pro®	Combipatch® (Novartis)
Clinoril®	sulindac (generic)
Clorpres®	clonidine HCl (generic), chlorthalidone (generic)
Cognex®	Aricept® (Eisai), Exelon® (Novartis), Razadyne® (Janssen Pharmaceutical)
Colestid®	cholestyramine(generic), Welchol® (Sankyo)
Coreg®	carvedilol (generic)
Corgard®	nadolol (generic)
Corzide®	bisoprolol fumarate/hydrochlorothiazide (generic), metoprolol/hydrochlorothiazide (generic), propranolol HCl/hydrochlorothiazide (generic)
Covera-HS®	verapamil HCl tablet, sustained action (generic)
Cytotec®	misoprostol (generic)
Dallergy® syrup	pseudoephedrine HCl/brompheniramine maleate (generic)
Dalmane®	flurazepam HCl (generic)
Daypro®	oxaprozin (generic)
Deconamine® tablet	pseudoephedrine w/chlorpheniramine (generic)
Demulen®	Zovia® (Watson-branded generic)
Desogen®	Apri® (Barr-branded generic), Solia® (Prasco Labs-branded generic)
Desyrel®	trazodone HCl (generic)
Dexchlorpheniramine Maleate®	clemastine fumarate (generic), fexofenadine HCL (generic), hydroxyzine HCl (generic), Clarinex® (Schering)
DiaBeta®	glyburide (generic)
Diabinese®	chlorpropamide (generic)
Diclofenac Potassium	etodolac (generic), ibuprofen (generic), naproxen (generic)
Diclofenac Sodium	etodolac (generic), ibuprofen (generic), naproxen (generic)
Diflucan®	fluconazole (generic)
Dilacor XR®	diltiazem XR (generic)
Dispermox®	amoxicillin trihydrate suspension (generic), amoxicillin trihydrate chewable tablet (generic)

Brand-Name Drug	Alternative
Ditropan XL®	oxybutyrin chloride ER (generic)
Doral®	temazepam (generic), triazolam (generic), zaleplon (generic), zolpidem tartrate (generic), Restoril® (Mallinckrodt)
Doryx®	doxycycline hyclate (generic)
Duoneb®	ipratropium/albuterol sulfate (generic)
Duricef®	cefadroxil hydrate (generic)
Dynacin®	minocycline HCl (generic), myrac (generic)
DynaCirc®	isradipine (generic), amlodipine besylate (generic), nifedipine ER (generic), Sular® (First-Horizon)
DynaCirc CR®	amlodipine besylate (generic), nifedipine ER (generic), Sular® (First-Horizon)
EC-Naprosyn®	naproxen (generic)
Effexor®	venlafaxine HCl (generic)
Elavil®	amitriptyline HCl (generic)
Elestrin®	estradiol patch (generic), Climara® (Berlex), Estraderm® (Novartis), Vivelle® (Novogyne)
Emsam®	tranylcypromine sulfate (generic), Nardil® (Parke-Davis)
Enduronyl Forte®	hydrochlorothiazide (generic), methyldopa/HCTZ (generic)
EryPed® Chewable Tablet 200 mg	erythromycin ethylsuccinate (generic)
EryPed® Suspension 400mg/5ml	erythromycin ethylsuccinate suspension 400mg/5ml (generic)
Estrace Tablet®	estradiol (generic)
Estrace Vaginal Cream®	Premarin Vaginal Cream® (Wyeth)
Estrasorb®	estradiol patch (generic)
Estrogel®	estradiol (generic), Climera Patch® (Berlex), Estraderm Patch® (Novartis), Vivelle Patch® (Novogyne)
Estrostep Fe®	Apri® (Barr-branded generic), Kariva® (Barr-branded generic), Microgestin Fe® (Watson-branded generic), Cylessa® (Organon)
Factive®	ciprofloxacin (generic), Levaquin® (J&J)
Feldene®	piroxicam (generic)
Femhrt®	estradiol/norethindrone acetate (generic), Activella® 0.5-0.1mg(Novo Nordisk), Premphase ®(Wyeth), Prempro® (Wyeth)
Femring®	Estring® (Pfizer), Premarin Vaginal Cream® (Wyeth)
Femtrace®	estradiol (generic)
Flonase®	fluticasone propionate (generic)
Floxin®	ofloxacin (generic)
Fortamet®	meformin HCL ER (generic), metformin HCl tablet (generic)
Fosamax®Tablets	alendronate sodium (generic)
Gantrisin®	sulfisoxazole (generic)
Geocillin®	ciprofloxacin HCl (generic)
Glucophage®	metformin HCl (generic)
Glucophage XR®	metformin HCl ER (generic), metformin HCl tablet (generic)
Glucotrol®	glipizide (generic)
Glucotrol XL®	glipizide ER (generic)

Brand-Name Drug	Alternative
Glucovance®	glyburide/metformin HCl (generic)
Glynase®	glyburide, micronized (generic)
Glyset®	acarbose (generic)
Grifulvin V®	griseofulvin ultramicrosize (generic), itraconazole (generic), ketoconazole (generic), terbinafine HCL (generic)
Gris-Peg ®	griseofulvin ultramicrosize (generic), itraconazole (generic), ketoconazole (generic), terbinafine HCL (generic)
Guanabenz Acetate®	clonidine HCl tablet (generic), methyldopa (generic)
Halcion®	triazolam (generic)
Hiprex®	methenamine hippurate (generic)
Hytrin®	terazosin (generic)
Imitrix®	sumatriptan succinate (generic)
Inderal®	propranolol HCl (generic)
Inderal LA®	propranolol capsule, sustained action (generic)
Indocin®	indomethacin (generic)
Innopran XL®	propranolol capsule, sustained action (generic)
Invega®	resperidone (generic), Geodon® (Pfizer), Serequel® (Astra Zeneca), Seroquel XR® (AstraZeneca), Zyprexa® (Eli Lilly)
Isoptin S.R.®	verapamil HCL tablet, sustained action (generic)
Kapidex®	omeprazole (generic), Nexium® (AstraZeneca)
Keflex®	cephalexin monohydrate (generic)
Kerlone®	betaxolol HCl (generic)
Ketek®	amoxicillin trihydrate/potassium clavulanate (generic), azithromycin (generic), Levaquin® (J&J)
Lamisil®	terbinafine HCL (generic)
Lescol®	lovastatin (generic), simvastatin (generic), Altoprev® (Andrx), Crestor® (AstraZeneca), Lipitor® (Pfizer), Vytorin® (Merck/Schering)
Lescol XL®	lovastatin (generic), simvastatin (generic), Altoprev® (Andrx), Crestor® (AstraZeneca), Lipitor® (Pfizer), Vytorin® (Merck/Schering)
Levatol®	acebutolol HCl (generic), atenolol (generic), metoprolol tartrate (generic)
Levlen®	Levora® (Watson-branded), Portia® (Barr-branded generic)
Levlite®	Aviane® (Barr-branded generic), Lessina® (Barr-branded generic), Lybrel® (Wyeth)
Lexapro®	citalopram (generic), fluoxetine HCl (generic), paroxetine HCl (generic), sertraline HCl (generic), Cymbalta® (Eli Lilly), Effexor XR® (Wyeth), Pristiq® (Wyeth)
Lexapro Solution®	citalopram solution (generic), fluoxetine HCl solution (generic), paroxetine HCL suspension (generic)
Lexxel®	amlodipine besylate/benazepril (generic)
Librium®	chlordiazepoxide HCl (generic)
Lodine ®	etodolac (generic)
Lodine XL®	etodolac (generic)
Loestrin®	Junel® (Barr-branded generic), Microgestin® (Watson-branded generic)
Loestrin FE®	Junel FE® (Barr-branded generic), Microgestin FE® (Watson-branded generic)
Loestrin 24 FE®	Junel FE® (Barr-branded generic), Microgestin FE® (Watson-branded generic)

Brand-Name Drug	Alternative
Lofibra®	fenofibrate (generic), Triglide® (First Horizon)
Lo/Ovral®	Low-Ogestrel® (Watson-branded generic)
Lopid®	gemfibrozil (generic)
Lopressor®	metoprolol tartrate (generic)
Lopressor HCT®	metoprolol/hydrochlorothiazide (generic)
LoSeasonique®	Aviane® (Barr-branded generic), Lutera® (Watson-branded generic)
Lotensin®	benazepril HCl (generic)
Lotensin HCT®	benazepril HCl/hydrochlorothiazide (generic)
Lotrel® 2.5-10mg, 5-10mg, 5-20mg, 10-20mg	amlodipine besylate/benazepril (generic)
Ludiomil®	maprotiline HCl (generic)
Lunesta®	temazepam (generic), zolpidem tartrate (generic), Ambien CR® (Sanofi-Aventis)
Luvox®	fluvoxamine maleate (generic)
Luvox CR®	fluvoxamine maleate (generic)
Macrobid®	nitrofurantoin macrocrystal (generic)
Macrodantin®	nitrofurantoin (generic)
Mandelamine®	methenamine mandelate (generic)
Mavik®	trandolapril HCl (generic)
Maxaquin®	ciprofloxacin HCl (generic), Levaquin® (J&J)
Menest®	estradiol (generic), estropipate (generic), Cenestin® (Duramed/Barr), Enjuvia® (Duramed/Barr), Premarin® (Wyeth)
Menostar Patch®	Climera Patch® (Berlex), Vivell Patch® (Novartis)
Metaglip®	glipizide/metformin (generic)
Mevacor®	lovastatin (generic)
Miacalcin®	calcitonin-salmon (generic)
Micronase®	glyburide (generic)
Midrin®	isometheptene/apap/dichloralphenazone (generic)
Migranal®	sumatriptan nasal spray (generic) , Zomig® Nasal Spray (AstraZeneca), Amerge® (GlaxoSmithKline), Frova® (Endo), Maxalt® (Merck), Relpax® (Pfizer)
Minipress®	prazosin HCl (generic)
Minocin®	minocycline HCl (generic)
Mircette®	Kariva® (Barr-branded generic)
Mobic®	meloxicam (generic)
Modicon®	Necon® (Watson-branded generic), Nortrel® (Barr-branded generic)
Monistat 3 Vaginal Suppository®	miconazole 3 vaginal suppository (generic)
Monodox®	doxycycline monohydrate (generic)
Monopril®	fosinopril sodium (generic)
Monopril HCT®	fosinopril hydrochlorothiazide (generic)
Monurol®	ciprofloxacin HCl (generic), sulfamethoxazole/trimethoprim (generic), trimethoprim (generic), Noroxin® (Merck)
Motrin®	ibuprofen (generic)
Moxatag®	amoxicillin (generic)

Brand-Name Drug	Alternative
Nalfon®	etodolac (generic), ibuprofen (generic), indomethacin (generic), meclofenamate sodium (generic), naproxen (generic), sulindac (generic),
Namenda Dose Pack®	Aricept® (Eisai), Exelon® (Novartis), Razadyne® (Janssen Pharmaceuticals)
Namenda Oral Solution®	Exelon Oral Solution® (Novartis), Razadyne Oral Solution® (Janssen Pharmaceuticals)
Namenda Tablet®	Aricept® (Eisai), Exelon® (Novartis), Razadyne® (Janssen Pharmaceuticals)
Naprelan®	naproxen sodium (generic)
Naprosyn®	naproxen (generic)
Nasacort®	Nasacort AQ® (Aventis)
Nasalide®	flunisolide (generic)
Nasarel®	flunisolide (generic), fluticasone propionate (generic), Nasacort AQ® (Aventis), Nasonex® (Schering), Rhinocort Aqua® (AstraZeneca)
Nembutal Sodium®	chloral hydrate (generic), temazepam (generic), triazolam (generic)
Nimotop®	nimodipine (generic)
Niravam®	alprazolam (generic)
Nitro-Dur®	nitroglycerin patch (generic), Minitran® (3M)
Nizoral®	ketoconazole (generic)
Nordette®	Levora® (Watson-branded generic), Portia® (Barr-branded generic)
Norinyl®	Necon® (Watson-branded generic), Nortrel® (Barr-branded generic)
Normodyne®	labetalol HCl (generic)
Norpramin®	desipramine HCl (generic)
Norvasc®	amlodipine besylate (generic)
Novolin®	Humulin® (Eli Lilly)
Ogen®	estropipate (generic)
Omnaris®	flunisolide (generic), fluticasone propionate (Generic), Nasacort AQ® (Aventis), Nasonex® (Schering), Rhinocort Aqua® (AstraZeneca)
Omnicef®	cefdinir (generic)
Orinase®	tolbutamide (generic)
Ortho-Cept®	Apri® (Barr-branded generic), Solia® (Prasco Labs-branded generic)
Orthoc-Cyclen®	MonoNessa® (Watson-branded generic), Previfem® (Teva-branded generic), Sprintec® (Barr-branded generic)
Ortho Evra®	MonoNessa® (Watson-branded generic), TriNessa® (Watson-branded generic)
Ortho Micronor®	norethindrone acetate (generic)
Ortho-Novum® 1/35, 7/7/7	Necon® (Watson-branded generic), Nortrel® (Barr-branded generic)
Ortho-Novum® 1/50	Necon® (Watson-branded generic)
Ortho-Prefest®	estradiol/norethindrone acetate (generic), Activella® 0.5-0.1mg (Novo Nordisk), Premphase® (Wyeth), Prempro® (Wyeth)
Ortho Try-Cyclen®	TriNessa® (Watson-branded generic), Tri-Previfem® (Teva-branded generic), Tri-Sprintec® (Barr-branded generic)
Oruvail®	ketoprofen (generic)
Ovcon®	Necon® (Watson-branded generic)
Ovral®	Ogestrel® (Watson-branded generic)
Pamelor®	nortriptyline HCl (generic)

Brand-Name Drug	Alternative
Parnate®	tranylcypromine sulfate (generic)
Paxil®	paroxetine HCl (generic)
Paxil CR®	paroxetine HCL sustained release tab (generic)
Paxipam®	clorazepate dipotassium (generic), diazapam (generic), lorazepam (generic), oxazepam (generic)
PCE®	erythromycin (generic)
Pepcid Suspension®	cimetidine HCl liquid (generic), famotidine (generic), Axid Oral Solution® (Braintree)
Pepcid Tablet®	famotidine (generic)
Periostat®	doxycycline hyclate (generic)
Pexeva®	paroxetine HCl (generic)
Phenergan®	promethazine HCl (generic)
Plendil®	felodipine ER (generic)
Ponstel®	etodolac (generic), ibuprofen (generic), indomethacin (generic), meclofenamate sodium (generic), naproxen (generic), sulindac (generic)
Prandimet®	metformin HCL (generic), Prandin® (Novo Nordisk)
Pravachol®	pravastatin (generic)
Precose®	acarbose (generic)
Prevacid®	omeprazole (generic), Nexium® (AstraZeneca)
Prilosec Rx®	omeprazole (generic), Nexium® (AstraZeneca)
Primsol®	trimethoprim (generic)
Prinivil®	lisinopril (generic)
Prinzide®	lisinopril/hydrochlorothiazide (generic)
Procardia XL®	nifedipine ER tablet, sustained release, osmotic push (generic)
Proquin XR®	ciprofloxacin HCL (generic)
ProSom®	estazolam (generic)
Protonix®Suspension	Nexium® Suspension (AstraZeneca)
Protonix®Tablet	pantoprazole sodium (generic), omeprazole (Generic), Nexium® (AstraZeneca)
Proventil®	albuterol (generic)
Proventil HFA®	Proair HFA® (Teva), Xopenex HFA® (Sepracor)
Prozac®	fluoxetine HCl (generic)
Prozac Weekly®	fluoxetine HCl (generic)
Questran®	cholestyramine (generic), prevalite (generic)
Questran Light®	cholestyramine/aspartame (generic), prevalite (generic)
Raniclor®	cefaclor suspension (generic), cefaclor capsule (generic)
Razadyne® tablet	galantamine (generic)
Relafen®	nabumetone (generic)
Remeron®	mirtazapine soltabs (generic), mirtazapine tabs (generic)
Restoril®15mg, 30mg	temazepam (generic)
Riomet Solution®	metformin HCl (generic)
Risperdal Tablet®	risperidone (generic)

Brand-Name Drug	Alternative
Risperdal Oral Solution®	risperidone (generic)
Rozerem ®	estazolam (generic), temazepam (generic), triazolam (generic), zolpidem tartrate (generic), Ambien CR® (Sanofi-Aventis)
Rynatan®	phenclor tannate pediatric (generic), brompheniramine/pseudophedrine (generic), pseudoephedrine HCl/chlorpheniramine maleate (generic)
Rynatuss®	carbetapentane/ephed/phenyleph/CP (generic)
Sanctura®	oxybutynin chloride (generic), oxybutynin chloride ER (generic), Detrol® (Pharmacia/Upjohn), Detrol LA® (Pharmacia/Upjohn), Enablex® (Novartis), Vesicare® (GlaxoSmithKline)
Sarafem®	fluoxetine HCL (generic)
Seasonale®	Jolessa® (Barr-branded generic), Quasense® (Watson-branded generic), Lybrel® (Wyeth), Seasonique® (Duramed/Barr)
Seconal Sodium®	chloral hydrate (generic), temazepam (generic), triazolam (generic)
Sectral®	acebutolol HCl (generic)
Semprex-D®	pseudoephedrine HCl/brompheniramine (generic), pseudoephedrine HCl/chlorpheniramine (generic)
Septra DS®	sulfamethoxazole/trimethoprim (generic)
Serax®	oxazepam (generic)
Serzone®	fluoxetine HCl (generic), paroxetine HCl (generic)
Sinequan®	doxepin HCl (generic)
Solodyn®	minocycline HCl (generic), doxycycline monohydrate (generic)
Sonata®	zaleplon (generic)
Spectracef®	cefaclor (generic), cefdinir (generic), cefuroxime axetil (generic)
Sporanox® capsule	itraconazole (generic)
Suprax®	cefdinir (generic), cefuroxime axetil (generic)
Surmontil®	trimipramine maleate (generic)
Symbyax®	fluoxetine HCl (generic), risperidone (generic), Seroquel® (AstraZeneca), Seroquel XR® (AstraZeneca), Zyprexa® (Eli Lilly),
Tagamet®	cimetidine (generic)
Tarka®	amlodipine besylate/benazepril (generic)
Tenex®	guanfacine HCl (generic)
Tenoretic®	atenolol/chlorthalidone (generic)
Tenormin®	atenolol (generic)
Tequin®	Levaquin® (J&J)
Terazol®	terconazol (generic)
Teveten®	Atacand® (AstraZeneca), Benicar® (Daiichi Sankyo), Cozaar® (Merck), Diovan® (Novartis), Micardis® (BIPI)
Teveten HCT®	Atacand HCT® (AstraZeneca), Benicar HCT® (Daiichi Sankyo), Diovan HCT® (Novartis), Hyzaar® (Merck), Micardis HCT® (BIPI)
Tiazac® 120mg, 180mg, 240mg, 300mg, 360mg	diltiazem HCl capsule, sustained release 24 hr (generic)
Tiazac® 420 mg	Cardizem LA® (Biovail)
Tofranil®	imipramine HCl (generic)

Brand-Name Drug	Alternative
Tolinase®	tolazamide (generic)
Toprol XL®	metoprolol succinate (generic)
Toradol®	etodolac (generic), ibuprofen (generic), indomethacin (generic), meclofenamate sodium (generic), naproxen (generic), sulindac (generic)
Toviaz®	oxybutynin chloride ER (generic), Detrol® (Pharmacia/Upjohn), Detrol LA® (Pharmacia/Upjohn), Enablex® (Novartis), Vesicare® (GlaxoSmithKline)
Trandate®	labetalol HCl (generic)
Tranxene SD®	clorazepate dipotassium (generic)
Tranxene T-Tab®	clorazepate dipotassium (generic)
Treximet®	naproxen (generic), Imitrex® (GlaxoSmithKline)
Tri-Levlen®	Enpresse® (Barr-branded generic), Trivora® (Watson-branded generic)
Tri-Norinyl®	Necon® (Watson-branded generic), Nortrel® (Barr-branded generic)
Triphasil®	Enepresse® (Barr-branded generic), Trivora® (Watson-branded generic)
Uniretic®	moexipril/hydrochlorothiazide (generic)
Univasc®	benazepril (generic), enalapril maleate (generic), lisinopril (generic), Aceon®(Solvay Pharmaceuticals), Altace® (Monarch)
Valium®	diazepam (generic)
Vantin Suspension®	cefaclor suspension (generic), cefdinir suspension (generic)
Vantin Tablet®	cefpodoxime proxetil tablet (generic)
Vaseretic®	enalapril maleate/hydrochlorothiazide (generic)
Vasotec®	enalapril maleate (generic)
Velosef®	cephradine (generic)
Ventolin®	albuterol (generic)
Ventolin HFA®	albuterol (generic) Proair HFA® (Teva), Xopenex HFA® (Sepracor)
Verelan®	verapamil ER (generic)
Verelan PM®	verapamil ER PM (generic)
Vfend Suspension®	Vfend Tablet® (Pfizer)
Vibramycin Syrup®	doxycycline monohydrate suspension (generic)
Vistaril®	hydroxyzine pamoate (generic)
Vivactil®	protriptyline HCL (generic)
Volmax®	albuterol sulfate (generic)
Voltaren®	etodolac (generic), ibuprofen (generic), naproxen (generic)
Voltaren-XR®	etodolac (generic), ibuprofen (generic), naproxen (generic)
Wellbutrin®	bupropion HCl (generic)
Wellbutrin SR®	bupropion HCl tablet, sustained release (generic)
Wellbutrin XL®	bupropion tablet, sustained release (generic)
Wytensin®	clonidine HCl tablet (generic), methyldopa (generic)
Xanax®	alprazolam (generic)
Xanax XR®	alprazolam XR(generic)
Xifaxan®	azithromycin (generic), ciprofloxacin HCl (generic)
Xolair®	Asmanex® (Schering), Flovent HFA® (GlaxoSmithKline), Pulmicort® (AstraZeneca), QVAR® (Ivax)

Brand-Name Drug	Alternative
Xyzal Solution®	fexofenadine HCL (generic), Allegra Suspension® (Aventis), Clarinex® Rapid Dissolve Tabs (Schering)
Xyzal Tablet®	fexofenadine HCL (generic), Clarinex® Tablet (Schering)
Yasmin®	Ocella (Barr-branded generic)
Zantac Rx Syrup®	ranitidine HCl tablet (generic), Axid Oral Solution® (Braintree)
Zantac Rx Tablet®	ranitidine HCl tablet (generic)
Zebeta®	bisoprolol fumarate (generic)
Zegerid®	omeprazole (generic), Nexium® (AstraZeneca)
Zestoretic®	lisinopril/hydrochlorothiazide (generic)
Zestril®	lisinopril (generic)
Ziac®	bisoprolol fumarate/hydrochlorothiazide (generic)
Zithromax®	azithromycin (generic)
Zmax®	azithromycin (generic)
Zocor®	simvastatin (generic)
Zoloft®	sertraline HCl (generic)
Zyflo®	Singulair® (Merck)
Zyflo CR®	Singulair® (Merck)

WPS HealthSense Rewards

WPS understands the importance of maintaining good health and recognizes the current demand for cost-effective health and wellness resources. To encourage and reward healthy behavior, we offer HealthSense Rewards,™ a free wellness program that provides discounted access to a variety of health clubs, weight-management centers, and other wellness resources for WPS customers.*

Reap the Rewards of Healthy Lifestyles.

HealthSense Rewards offers you and your family the opportunity to develop or maintain healthy habits without having to pay full price for health and wellness services. The benefits of a healthy lifestyle include stress reduction, improved overall health, and increased energy.

Start Enjoying Your Benefits Today.

To take advantage of HealthSense Rewards, simply present your WPS ID card when visiting or calling a participating facility. The discount is automatically applied at the time of purchase.**

Looking for More Information?

Visit the HealthSense Rewards page of our website at www.wpsic.com/healthsense to learn more about this program or obtain a list of participating facilities in your area. We update the list periodically, so check back often. If you have questions about any aspect of the HealthSense Rewards program, please call our Member Services department at the toll-free number listed on your WPS ID card.

*HealthSense Rewards is also available to all WPS subsidiaries.
**Although you don't pay any fee to WPS for HealthSense Rewards, each customer is solely responsible for paying costs charged for services or products he or she chooses to receive. WPS is not responsible or liable for the quality of care, services, or products provided by HealthSense Rewards wellness facilities.

PROVIDER INFORMATION

Provider Directory

You can access providers, hospitals, specialists, and more through our interactive, and easy-to-use online Provider Directory. It's updated regularly to offer you the most current listing of providers in your network. Simply follow these instructions to locate the provider(s) of your choice.

- Go to the WPS Web site at www.wpsic.com.
- Click the **Find a Doctor** link found on the home page.

You'll now be on the Find a Doctor main page.

- *If you are currently a member:*
  Enter your Member Number (found on your ID card) in the **Current Members...** section, then click **Continue.** If you are already logged in as a member, your Member Number will automatically be added to this field using hidden characters.

- *If your effective date has not yet arrived:*
  Your next step will depend on if you have a group or individual plan:
  - If your coverage is through your employer, select your network (found on your ID card) in the **My Employer is Considering WPS...** section, then click **Continue.**
  - If your coverage is through an individual plan, click the **Individual & HSA-Qualified Plan Doctors** link in the **Other Visitors...** section and select your network (found on your ID card) in the next page.

You will then be directed to the basic **Search** page. Here, you can search the WPS Provider Directory for a specific doctor, pull up a listing of multiple doctors, specialists, hospitals, clinics, etc., or find special information about your network. If Network Information is displayed at the bottom of the page, be sure to read through it.

The default is to **Search for a Doctor.** Or you may select the **Search for the Health Care Facility** option. Enter information under the search method you selected. To get the most useful results, please narrow your search by using more than one criteria.

- When searching for a doctor, you may enter the doctor's last name, the doctor's county and/or the doctor's specialty.
- When searching for a facility, you may enter the facility's name and/or its county.

The basic Search page provides fields for the most-used search criteria. You may also click the **Advanced Searching** link found at the top-right corner of the Search box to access more in-depth search options, such as city, state and zip code. Note that when entering a zip code, your results will be limited to that specific zip code.

After clicking the **Search** button, you'll be taken immediately to the Disclaimer page. Please read the disclaimer. Click **Continue to Search Results** to proceed to your chosen provider directory.

You've now come to the conclusion of your search by reaching the **Search Results** page. Here, you'll find a listing of all the providers that matched your search criteria. From here you can print a copy of your selected directory for your records, refine your search results or begin a new search.

If you have any questions, or don't have access to a computer, please call our Member Service department at 800-221-5313.

Optum Health

Specialized Care Services Company of United Health Care Corporation

Managed Transplant Care

Transplants are among the most costly and technical medical procedures you can encounter. That's why WPS Integrated Care Management offers Optum Health to help with the planning and coordination of transplant processes.

When you choose a transplant medical center that has contracted with Optum Health, you save money because your coinsurance for covered transplant services will be reduced or eliminated. If you and your doctor choose not to utilize a non-preferred provider coinsurance level, you remain liable for excluded amounts.

How Does It Work?

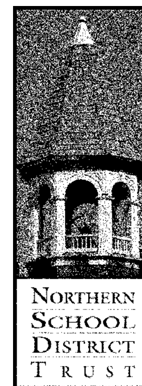
You can choose to receive covered transplant care at medical centers located throughout the United States that specialize in bone marrow and organ transplantation.

An extensive collection of clinical criteria, developed by the Optum Health and affiliated transplant physicians, is used to select medical centers. Members of the medical staff at these centers have vast experience. A combination of proven staff and quality facilities helps improve the likelihood of positive clinical outcomes and long-term survival, should a transplant be necessary.

Early intervention is critical to proper management of a potential transplant case.

As soon as you know you're a transplant candidate, you or your doctor should contact a Case Management Specialist or EPIC Medical Management toll free at 1-800-333-5003. WPS or EPIC will then assist with the planning and coordination of all covered transplant services, including any necessary follow-up care.

MEDICAL BENEFITS



NORTHERN SCHOOL DISTRICT TRUST
CHEQUAMEGON SCHOOLS
Employee Benefit Plan
PLAN DOCUMENT
AND
BENEFIT BOOK
Effective July 1, 2011

25232-051-1112

GENERAL INFORMATION ABOUT YOUR PLAN

Each Employer participating in the Northern School District Trust has established its own welfare benefit plan ("Plan"). Your Employer has elected certain medical benefits set forth in the Plan. All medical expenses covered under your health care benefit plan as described in this booklet are paid for by Northern School District Trust. This Plan is administered by Wisconsin Physicians Service Insurance Corporation (WPS) under a third party administrative agreement between Northern School District Trust, the plan sponsor, and WPS.

According to our records, we believe this coverage is a grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing.

However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Plan Administrator.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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

This booklet explains how the Plan works: what it pays for, what is not covered, how to submit expenses and claim benefits. Every medical cost situation cannot be specifically described in this material. If you have specific questions pertaining to coverage, please contact:

WPS Administrative Services
1717 West Broadway
P.O. Box 8190
Madison, Wisconsin 53708

Phone: Please call the number shown on your Plan Identification Card
Website: www.wpsic.com

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SCHEDULE OF BENEFITS

All health benefits shown on this Schedule of Benefits are subject to the individual lifetime and annual maximums, individual and family deductibles, co-pays, coinsurance, and out-of-pocket maximums, if any. Refer to this booklet for more information.

Benefits are also subject to all provisions of the Plan, including medical necessity and any other benefit determination based on an evaluation of medical facts and covered benefits. Refer to section COVERED MEDICAL BENEFITS of this booklet for more details.

Benefits are payable for charges for all covered expenses under the Plan. The term "charges" as used in this schedule means the amount that the Claim Administrator determines as reasonable for those covered expenses.

SUMMARY OF BENEFITS	PREFERRED PROVIDERS	ALL OTHER HEALTH CARE PROVIDERS
Individual Annual Maximum Benefit	$2,000,000	
Annual Deductible Amount	$500 per participant, not to exceed $1,000 per family	$1,000 per participant, not to exceed $2,000 per family
Annual Out-of-Pocket Limit	$500 per participant, not to exceed $1,000 per family	$2,000 per participant, not to exceed $4,000 per family
Ambulance Services	Deductible, then 100% of charges	Deductible, then 100% of charges
Chiropractic services	Deductible, then 100% of charges	Deductible, then 80% of charges
Contraceptives - IUDs, implants, diaphragms and injections	Deductible, then 100% of charges	Deductible, then 80% of charges
Diagnostic X-Rays and Laboratory Services	Deductible, then 100% of charges	Deductible, then 80% of charges
Durable Medical Equipment	Deductible, then 100% of charges	Deductible, then 80% of charges
Emergency Room Visits - includes all services provided in the emergency room	Emergency room charge: $25 copay, then 100% of charges Related services in the emergency room: then 100% of charges	Emergency room charge: $25 copay, then 100% of charges Related services in the emergency room: then 100% of charges
Home Health Care Services	Deductible, then 100% of charges	Deductible, then 80% of charges
Hospital Services		
Inpatient services billed as emergency medical care	Deductible, then 100% of charges	Preferred deductible, then 100% of charges
Inpatient services billed as other than emergency medical care	Deductible, then 100% of charges	Deductible, then 80% of charges
Outpatient hospital services (other than emergency room services)	Deductible, then 100% of charges	Deductible, then 80% of charges
Immunizations	100% of charges	100% of charges
Nervous and Mental Disorders, Drug Abuse and Alcoholism Services	Inpatient Services: Deductible, then 100% of charges Outpatient Services: Deductible, then 90% of charges Outpatient Services for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHDD): 100% of charges Transitional Treatment: Deductible, then 100% of charges	Inpatient Services: Deductible, then 80% of charges Outpatient Services: Deductible, then 80% of charges Outpatient Services for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHDD): 100% of charges Transitional Treatment: Deductible, then 80% of charges

SUMMARY OF BENEFITS	PREFERRED PROVIDERS	ALL OTHER HEALTH CARE PROVIDERS
Nutritional counseling for the management of diabetes	Deductible, then 100% of charges	Deductible, then 80% of charges
Physician Office Visits Billed as Emergency Medical Care	Office visit charge: $25 copay, then 100% of charges Related services: Deductible, then 100% of charges	Office visit charge: $25 copay, then 100% of charges Related services: Preferred deductible, then 100% of charges
Physician Office Visits Billed as Other than Emergency Medical Care	Deductible, then 100% of charges	Deductible, then 80% of charges
Prescription Drugs Dispensed by a Physician's Office, Outpatient Department of a Hospital or Home Health Agency Prescription drugs that can be dispensed by a pharmacy are not covered	Deductible, then 100% of charges	Deductible, then 80% of charges
Preventive (routine) services: Includes exams, including eye and hearing exams, and related routine laboratory services	100% of charges	100% of charges
Skilled Nursing Facility - limited to 60 days per confinement	Deductible, then 100% of charges	Deductible, then 80% of charges
Temporomandibular Joint Disorder Services	Deductible, then 100% of charges	Deductible, then 80% of charges
Therapy Services	Deductible, then 100% of charges	Deductible, then 80% of charges
Transplant Services - limited as stated in the Plan	Deductible, then 100% of charges	Deductible, then 80% of charges
All Other Health Services	Deductible, then 100% of charges	Deductible, then 80% of charges

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

This notice is intended to inform you that pursuant to a new law, the Women's Health and Cancer Rights Act, you will be receiving additional benefits under your group health plan beginning on January 1, 1999.

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA which amends ERISA, requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because your group health plan offers coverage for mastectomies, WHCRA applies to your plan. The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible and coinsurance provisions otherwise applicable under your group health plan.

If you have any questions regarding these benefits, please contact WPS Administrative Services, A Division of Wisconsin Physicians Service Insurance Corporation, at the toll-free number listed on your group health plan ID card.

DISCRETIONARY AUTHORITY

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Claim Administrator. Any interpretation, determination or other action of the Plan Administrator or Claim Administrator shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator or Claim Administrator shall be based only on such evidence presented to or considered by the Plan Administrator or the Claim Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Claim Administrator makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described by this section.

FEDERAL NEWBORNS AND MOTHERS HEALTH PROTECTION PROVISION

Group health plans and health insurance issuers offering group health coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain pre-certification from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

MEDICARE AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if the premium assistance is available at (for Wisconsin) 1-800-362-3002 or http://dhs.wisconsin.gov/Medicaid/publications/p-10095.htm.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insuredkidsnow.gov to find out how to apply. If you qualify, you can ask the State if is has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Definitions

The following definitions apply to this section:

Covered Entity: a health plan (as defined in 45 C.F.R. section 160.103); a health care clearinghouse; or a health care provider who transmits any health information in electronic form in connection with a transaction covered by the provisions of this section.

Health Information: any information, oral or recorded in any medium, that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment for the provision of the health care to a participant.

Individually Identifiable Health Information: information that is a subset of health information, including demographic information collected from a participant, and: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment for the provision of the health care to a participant; and (i) that identifies the participant; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the participant.

Plan Administration Functions: administration functions performed by the Employer on behalf of the Plan and excludes functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

Protected Health Information: individually identifiable health information that is or has been electronically maintained or electronically transmitted by a covered entity, as well as such information when it takes any other form or medium. Protected health information excludes individually identifiable health information in: (1) education records covered by the Family Education Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (2) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (3) employment records held by a covered entity in its role as employer.

Summary Health Information: information, that may be individually identifiable health information, and: (1) that summarizes the claims history, claims expenses, or type of claims experienced by participants for whom the Employer has provided health benefits under the Plan; and (2) from which the identifiers of the participants or of relatives, employers, or household members of the participant specified in 45 C.F.R. section 154.504(a), are removed.

Disclosure of Protected Health Information

This section reflects the modification of the Plan as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to allow the disclosure of protected health information ("PHI") to the Employer, for the purposes specified below.

1. Use and Disclosure of PHI by the Employer.

The Employer shall use and/or disclose PHI only to the extent necessary to perform Plan administration functions, which it performs on behalf of the Plan.

2. Disclosure of PHI to the Employer.

The Plan shall disclose PHI to the Employer only to the extent necessary to perform Plan administration functions.

The Plan agrees that it will only disclose PHI to the Employer when this section has been adopted and the Employer agrees to abide by the provisions of this section as evidenced by certification attached to the Plan. The Employer is subject to the following:

a. **Prohibition on Unauthorized Use or Disclosure of PHI.** The Employer will not use or disclose any PHI received from the Plan, except as permitted in this section or required by law.

b. **Subcontractors and Agents.** The Employer will require each of its subcontractors or agents to whom the Employer may provide PHI to agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Employer.

c. **Permitted Purposes.** The Employer will not use or disclose PHI for employment-related actions and decisions or in connection with any other of the Employer's benefits or employee benefit plans.

d. **Reporting.** The Employer will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for which it becomes aware.

e. **Access to PHI by Participants.** The Employer will make PHI available to the Plan to permit participants to inspect and copy their PHI contained in the designated record set, in accordance with 45 C.F.R. section 164.524.

f. **Correction of PHI.** The Employer will make a participant's PHI available to the Plan to permit participants to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and the Employer will incorporate amendments provided by the Plan, in accordance with 45 C.F.R. section 164.526.

g. **Accounting of PHI.** The Employer will make a participant's PHI available to permit the Plan to provide an accounting of disclosures, in accordance with 45 C.F.R. section 164.528.

h. **Disclosure to Government Agencies.** The Employer will make its internal practices, books and records relating to the use and disclosure of PHI available to the Department of Health and Human Services for purposes for purposes of determining the Plan's compliance with the HIPAA Privacy Rule.

i. **Return or Destruction of Health Information.** When the PHI is no longer needed for the purpose for which disclosure was made, the Employer must, if feasible, return to the Plan or destroy all PHI that the Employer received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Employer agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

j. **Electronic PHI.** The Employer agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan, and it will ensure that any agent, including a subcontractor, to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

3. Adequate Separation.

The Employer represents that adequate separation exists between the Plan and the Employer so that PHI will be used only for Plan administration. The following employees or classes of employees or other persons under the control of the Employer have access to participants' PHI to perform Plan administration functions: the Employer's Human Resource Department or any employee with oversight responsibility for claims administration.

The Employer will ensure that the provisions of this paragraph 3. are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

4. Adequate Separation Certification.

The Plan requires the Employer to certify that the employees identified above are the only employees that will access and use participants' PHI. The Employer must further certify that such employees will only access and use PHI to perform Plan administration functions.

5. Enrollment/Disenrollment Information.

Notwithstanding the above, the Plan, or a health insurance issuer, HMO or TPA with respect to the Plan, may disclose to the Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

6. Summary Health Information.

Notwithstanding the above, the Plan, or a health insurance issuer, HMO or TPA with respect to the Plan may disclose summary health information to the Employer, provided the Employer requests the summary health information for the purpose of: (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

7. Reports of Non-Compliance.

Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Official or other Plan representative to help resolve any potential issues of non-compliance.

MEDICAL MANAGEMENT

Prior Approval of Health Care Services Provided by a Health Care Provider Other Than a Preferred Provider

Our prior approval is required in order to receive benefits for charges for covered expenses for certain health care services provided by a health care provider other than a preferred provider. Health care services requiring our prior approval are listed below. You are responsible for assuring that the required prior approval is received before health care services are provided by calling 1-800-333-5003. Please allow up to 15 business days for the review process. Failure to comply with the prior approval requirement may result in a lower level of benefits being paid or no coverage for such health care services.

To assure that health care services are covered at the highest level, you must obtain our prior approval before you receive any of the following health care services:

1. Any prosthetic with a total purchase price greater than $3,000 (see subsection "Prosthetics");

2. Any durable medical equipment that will be rented for more than three months or with a total purchase price greater than $3,000 (see subsections "Durable Medical Equipment");

If you don't obtain our prior approval before you receive any health care service listed above, benefits for that health care service will be reduced by 20% if medically necessary and not experimental, subject to all terms, conditions and provisions of the Plan.

Preadmission Certifications

You must notify us if your attending physician recommends that you be admitted to a: (1) hospital, other than a preferred hospital, for treatment of an illness or injury; or (2) a residential treatment program in a facility other than a preferred provider, for treatment of alcoholism, drug abuse or nervous or mental disorders. You must notify us:

1. at least three business days prior to the proposed admission date for non-emergency admissions; or

2. within two business days of an admission date for emergency admissions.

The notice must be in writing or given by telephone by calling us at 1-800-333-5003.

If you do not notify us as stated above, benefits otherwise payable for your confinement will be reduced by 20% for that confinement.

We will determine the number of medically necessary days for which benefits are payable under the Plan. No benefits are payable for confinement in a hospital or residential treatment program or any days which we determine are not medically necessary.

Even though you provide notification, that does not guarantee that the Plan will pay for the health care services. You still need to be eligible for coverage on the date health care services are provided and those health care services must be medically necessary.

Prenatal and Maternity Care Notification

If you're pregnant, we request that you also notify us by calling us at 1-800-333-5003:

1. after your first prenatal visit; and

2. within 24 hours or the first business day following the date of your delivery.

Although your failure to provide such notice won't reduce benefits otherwise payable for such health care services, your notice to us will allow us to work with you and your physician during your pregnancy to help coordinate medically necessary health care services and provide high-risk screening and health information.

Alternate Care

If we determine that a health care service, other than what you are currently receiving, could be provided with better outcomes at a lesser or equal price, and the proposed health care service is not excluded under the Plan, we will contact your attending physician to: (1) suggest his/her consideration of the alternate care; and (2) advise him/her of the possible benefits payable by us for charges for such alternate care.

Benefits are payable for charges incurred for the alternate care as provided under the Plan. In the event that the alternate care includes health care services for which benefits are not otherwise payable under the Plan, we, at our option, will consider the payment of benefits under the Plan for charges incurred for such health care services as long as such health care services are medically necessary and the original course of treatment would have been covered under the Plan. Benefits, if any, shall be paid only as determined by us.

Preauthorization Procedure

This subsection describes the types of health care services that should be preauthorized but are not required to be prior approved.

We do not pay benefits for health care services that are experimental, investigative or not medically necessary or excluded from coverage, as determined by us. We know it is difficult for you to determine whether any health care services will be covered before starting treatment. Please visit our internet website at www.wpsic.com for the most current list of services that we recommend be preauthorized.

The types of health care services that may fall into this category, but not limited to these, are:

1. New medical or biomedical technology;

2. Services performed as part of a research study or clinical trial;

3. Varicose vein treatment;

4. Exercise programs;

5. Acupuncture;

6. Evaluation and treatment of sleep disorders, such as polysomnograms (sleep studies);

7. PET scans; and

8. MRIs and MRAs.

If you want to submit a "preauthorization" request to us, your provider may submit a written or faxed preauthorization request. A medical request form is available on our website at www.wpsic.com. After we receive a preauthorization request, we will make a determination on whether or not to pre-authorize benefits for the health care service based upon the information available to us at the time we receive the preauthorization request. We'll send you our written response to your preauthorization request, telling you whether the health care service is covered.

However, even if a health care service is preauthorized in writing by us, no benefits will be paid unless after receiving the proof of claim, we determine that benefits are payable for that health care service under the Plan.

If you do not use this preauthorization procedure, we may decide that the health care service is: (1) experimental or investigative; (2) not medically necessary; (3) excluded under the Plan; or (4) not payable for some other reason under the Plan. No payment can then be made for the health care service or any related health care service.

If you or your physician disagrees with our decision, you may appeal that decision by submitting to us documentation from the treating physician as to the medical value or effectiveness of the health care service. Please see subsection "Claim Appeal Procedure". If you use that procedure, the decision made by us at that time will be final.

DEFINITIONS

The following definitions shall apply to this Plan:

Active Work/Actively at Work: when an employee is performing all of the duties of his/her principal occupation in his/her job with the Employer for a minimum of 20 hours per week, and paid a reasonable wage, as determined by the Claim Administrator. These duties must be performed at the Employer's place of business, except to the extent that the employee must travel to perform his/her duties. The employee shall be deemed to be actively at work on: (1) each day of a paid vacation; or (2) a regularly-scheduled non-work day, provided that, in either case, he/she worked his/her entire last regularly-scheduled work day prior to such date.

Alcoholism: a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within a classification category or code 303 - Alcohol Dependence Syndrome, 304 - Drug Dependence, and 305 - Nondependent abuse of drugs and 291 - Alcohol-induced Mental Disorders or 292 - Drug-Induced Mental Disorders.

Bone Anchored Hearing Device (BAHA): a surgically implantable system for treatment of hearing loss that works through direct bone conduction.

Calendar year: the period of time that starts with the participant's applicable effective date of coverage in the Plan and ends on December 31st of such year. Each following calendar year shall start on January 1st of any year and end on December 31st of that same year.

Certified Nurse Midwife: a person who is a registered nurse and is certified to practice as a nurse midwife by the American College of Nurse Midwives and by either the State of Wisconsin or by the state in which he/she practices.

Charge: an amount for a health care service that is reasonable, as determined by the Claim Administrator. The Claim Administrator takes into consideration, among other factors (including national sources) determined by the Claim Administrator: (1) amounts charged by health care providers for similar health care services when provided in the same geographical area; (2) our methodology guidelines; (3) pricing guidelines of any third party responsible for pricing a claim; and (4) the negotiated rate determined by the Claim Administrator in accordance with the applicable contract between the Claim Administrator and that preferred provider. As used herein, ,the term "area" means a county or other geographical area which the Claim Administrator determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. In some cases the amount the Claim Administrator determines as reasonable may be less than the amount billed. Charges are incurred on the date the participant receives the health care service.

In some cases the Claim Administrator may determine that the health care provider or its agent didn't use the appropriate billing code to identify the health care service provided to a participant. The Claim Administrator reserves the right to recodify and assign a different billing code to any health care service that the Claim Administrator determines was not billed using the appropriate billing code.

Claim Administrator: WPS Administrative Services, a division of Wisconsin Physicians Service Insurance Corporation, acting as the health claim administrator under the terms of an Administrative Services Agreement with the Northern School District Trust.

Cochlear Implant: any implantable instrument or device that is designed to enhance hearing.

Confinement/Confined: the period starting with a participant's admission on an inpatient basis (more than 24 hours) to a hospital or other licensed health care facility for treatment of an illness or injury. Confinement ends with the participant's discharge from the same hospital or other facility.

Convenient Care Clinic: a medical clinic that is located in a retail store, supermarket or pharmacy providing covered health care services by nurse practitioners, physician assistants or physicians within the scope of their respective licenses. A convenient care clinic provides health care services to treat minor illnesses and injuries, and preventive services.

Copayment: that portion of the charge for a covered expense which a participant is required to pay to the health care provider for a certain health care service covered under the Plan. Copayments are a specific dollar amount.

Cosmetic Treatment: any health care services used to improve either the patient's physical appearance or self-esteem. Treatment of a condition due to psychological symptoms without a functional impairment is considered cosmetic treatment.

Covered Dependent: a dependent who meets all of the following requirements: (1) he/she is eligible for coverage under the Plan; (2) he/she has properly enrolled; and (3) he/she is approved by us for coverage under the Plan.

Covered Employee: an employee who meets all of the following requirements: (1) he/she is employed by the Employer; (2) he/she is eligible for coverage under the Plan; (3) he/she has properly enrolled; and (4) he/she is approved by us for coverage under the Plan. Where applicable, a covered employee shall include a covered retiree.

Covered Retiree: a retiree who meets all of the following requirements: (1) he/she is eligible for coverage under the Plan; and (3) he/she has properly enrolled; and (4) he/she is approved by us for coverage under the Plan.

Creditable Prior Coverage: any group coverage including: FEHBP and Peace Corps, any group self-insured group health plans, governmental plans and church plans; individual health benefits coverage including short-term limited coverage, Medicaid, including BadgerCare Plus, Medicare, Military-sponsored health care programs, Indian Health Service or tribal organization coverage, state high risk pool coverage, a public health plan or a flexible spending account which includes medical benefits (as defined in the Federal Regulations).

Custodial Care: health care services given to a participant if: (1) the participant does not require the technical skills of a registered nurse at all times; (2) the participant needs assistance for activities of daily living, including, but not limited to, dressing, bathing, eating, walking, taking medications or maintaining continence; and (3) the health care services the participant requires are not likely to improve his/her physical and/or mental condition. Health care services may still be considered custodial care, as determined by the Claim Administrator, even if: (1) the participant is under the care of a physician; (2) the physician prescribes health care services to support and maintain the participant's physical and/or mental condition; or (3) health care services are being directly provided to a participant by a registered nurse or licensed practical nurse, a physical, occupational, or speech therapist, or a physician.

Deductible: the amount of charges for covered expenses which a participant is required to pay to a health care provider for certain health care services covered under the Plan received from the health care providers in a calendar year before benefits are payable under the Plan.

Department: The State of Wisconsin Department of Health and Family Services.

Dependent: see subsection "Eligible Dependent" of section "ELIGIBILITY AND COVERAGE" for dependent eligibility.

Direction: verbal or written instructions, standing orders or protocols issued by a physician or health care provider.

Drug Abuse: a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within a classification category or code 303 - Alcohol Dependence Syndrome, 304 - Drug Dependence, and 305 - Nondependent abuse of drugs, and 291 - Alcohol-induced Mental Disorders or 292 - Drug-Induced Mental Disorders.

Durable Medical Equipment: an item which can withstand repeated use and is, as determined by us: (1) primarily used to serve a medical purpose with respect to an illness or injury; (2) generally not useful to a person in the absence of an illness or injury; (3) appropriate for use in the participant's home; (4) prescribed by a physician; and (5) medically necessary. All requirements of this definition must be satisfied before an item can be considered to be durable medical equipment.

Emergency Medical Care: medical services directly provided by a health care provider to treat a participant's medical emergency. A medical emergency is 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 immediate medical attention will likely result in any of the following:

1. serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;

2. serious impairment to the person's bodily functions; or

3. serious dysfunction of one or more of the person's body organs or parts.

Employee: see subsection "Eligible Employee" of section "ELIGIBILITY AND COVERAGE" for employee eligibility.

Employer: CESA Schools, a member of the Northern School District Trust as defined in the trust agreement.

Experimental or Investigative: As determined by the Claim Administrator's Corporate Medical Director, the use of any health care services for a participant's illness or injury that, at the time it is used, meets one or more of the following:

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

2. isn't yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or

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

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

Additional criteria that the Claim Administrator uses for determining whether a health care service is considered to be experimental or investigative and, therefore, not covered, for a particular illness or injury include, but are not limited to:

1. what are its failure rate and side effects;

2. whether other more conventional methods of treatment have been first exhausted;

3. whether it is medically necessary for the treatment of that illness or injury;

4. whether it is universally recognized as not experimental or investigative by Medicare, Medicaid and other third party payers (including insurers and self-funded plans); or

5. whether any documentation refers to the health care service as posing an uncertain outcome or having an unusual risk.

Investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended, and drugs which by law require a written prescription used in the treatment of cancer that may not currently have FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis, are covered under the Plan to the extent described in paragraph 11. of subsection "Covered Expenses," if applicable.

To question whether a particular health care service is considered experimental or investigative, please see subsection "Preauthorization Procedure" under section "MEDICAL MANAGEMENT."

The determination of whether a health care service is experimental or investigative under the definition set out above and the Claim Administrator's criteria shall be made by the Claim Administrator in its sole and absolute discretion. In any dispute arising as a result of the Claim Administrator's determination, such determination shall be upheld if the decision is based on any credible evidence. In any event, if the decision is reversed, the limit of liability under the Plan or on any other basis shall be to provide Plan benefits only and neither compensatory nor punitive damages, nor attorney's fees, nor other costs of any kind shall be awarded in connection therewith or as a consequence thereof.

Family Coverage: means coverage applies to a covered employee and his/her covered dependents.

Full-Time Student: an adult child of a covered employee who meets the following criteria:

1. the child is a full-time student, regardless of age; and

2. the child is not married, unless the child is under age 26; and

3. the child must not be eligible for coverage under a group health benefit plan as an employee; or

4. the child is eligible under a group health benefit plan as an employee for which the amount of the child's premium contribution is greater than the premium amount for his/her coverage as a dependent under the Plan; and

5. the child was called to federal duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education; and

6. the child was under the age of 27 when called to federal active duty.

The adult child must: (1) attend an accredited school for the number of credits, hours, or courses required by the school to be considered a full-time student; or (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his/her degree. The adult child continues to be a full-time student during periods of vacation or between term periods established by the school.

Functional Impairment: a deficit in a participant's ability to perform the basic activities of daily living (ADL's), such as dressing, bathing, and eating or the instrumental activities of daily living such as using transportation, shopping or handling finances.

Health Care Provider: any person, institution or other entity licensed by the state in which he/she or it is located to provide health care services covered by the Plan to a participant, within the lawful scope of his/her or its license.

Health Care Services: treatment, services, procedures, drugs or medicines, devices, or supplies directly provided to a participant and covered under the Plan, except to the extent that such treatment, services, procedures, drugs or medicines, devices, or supplies are limited or excluded under the Plan.

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

Home Care: health care services directly provided to a participant in his/her home under a written home care plan. The attending physician must set up the home care plan. Such plan must be approved in writing by that physician. He/she must review it at least every two months; but this can be less frequent if he/she decides longer intervals are enough and the Claim Administrator agrees.

Home Visit:

1. for health care services other than health care services for treatment of nervous or mental disorders, drug and alcohol abuse, a participant's meeting with a physician or other health care provider when billed by a physician in a participant's home. During that meeting the participant must receive from the physician or other health care provider: (a) medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology); or (b) manipulations by a physician, other than services related to physical therapy.

2. for health care services for treatment of nervous or mental disorders, drug and alcohol abuse, a participant's meeting with a licensed psychiatrist, a licensed or certified psychologist, or a health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse in the participant's home. During that meeting you must receive: (a) psychotherapy; (b) psychiatric diagnostic interviews; (c) medication management; (d) electro-shock therapy; (e) behavioral counseling; or (f) neuropsychological testing.

Hospice Care: health care services provided to a participant whose life expectancy, as certified by a physician, is six consecutive months or less, and which are provided by a licensed hospice care provider approved by us. The care must be available on an intermittent basis with on-call health care services available on a 24-hour basis. Such care shall include health care services provided to ease pain and make the participant as comfortable as possible.

Hospital: an institution providing 24-hour continuous service to confined patients. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons. A professional staff of licensed physicians and surgeons must provide or supervise its services. It must provide general hospital and major surgical facilities and services. A hospital also includes a specialty hospital approved by the Claim Administrator and licensed and accepted by the appropriate state or regulatory agency to provide diagnosis and short term treatment for patients who have specified medical conditions. A hospital does not include, as determined by the Claim Administrator: (1) a convalescent or extended care facility unit within or affiliated with the hospital; (2) a clinic; (3) a nursing, rest or convalescent home or extended care facility; (4) an institution operated mainly for care of the aged or for treatment of mental disease, drug addiction or alcoholism; (5) sub-acute care center; or (6) a health resort, spa or sanitarium.

Illness: a physical illness, alcoholism, drug abuse, or a nervous or mental disorder.

Immediate Family: a covered employee's spouse, natural and adopted children, parents, grandparents, brothers, and sisters, and the spouses of such persons.

Implantable Hearing Device: any implantable instrument or device that is designed to enhance hearing, including cochlear implants and bone anchored hearing devices.

Incidental: associated services or items which are integral to the performance of another service or item, or which does not add significant time or effort to the other service or item.

Infertility: the physical inability to conceive after at least 12 consecutive months of unprotected sexual intercourse, and such inability is documented by a health care provider.

Injury: bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes. An accident caused by chewing resulting in damage to a participant's teeth is not considered an injury.

Late Enrollee: an eligible employee, or dependent of an eligible employee, who does not request coverage under the Plan during an enrollment period during which the person is entitled to enroll for coverage under the Plan and who subsequently requests coverage under the Plan.

A late enrollee does not include:

1. a person who:

  a. was covered under creditable prior coverage at the time the person was eligible to enroll; and

  b. states, at the time of enrollment, that coverage under another health benefit plan was the reason for declining enrollment; and

  c. has lost coverage under creditable prior coverage involuntarily; and

  d. requests enrollment within 31 days after the involuntary loss of his/her creditable prior coverage; or

  e. requests enrollment under the Plan within 60 days after the loss of eligibility for Medicaid, including BadgerCare Plus; or

  f. requests enrollment under the Plan within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, has been determined; or

2. a person who is employed by an employer who offers multiple health benefit plans and the person elects a different health benefit plan during an open enrollment period; or

3. a person who a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made.

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

Low-Dose Mammography: the x-ray examination of a breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Maintenance Care: health care services provided to a patient after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. Such care promotes optimal function in the absence of significant symptoms.

Maternity Services: professional services for prenatal and postnatal care. This includes: laboratory procedures; delivery of the newborn; cesarean and porro-cesarean sections; and care for miscarriages.

Medicaid/Medical Assistance: benefits available under state plans pursuant to Title XIX of the Social Security Act of 1965, as amended.

Medically Necessary: a health care service directly provided to a participant by a hospital, physician or other health care provider that is required to identify or treat the participant's illness or injury and which is, as determined by the Claim Administrator: (1) consistent with the symptom(s) or diagnosis and treatment of his/her illness or injury; (2) furnished for an appropriate duration and frequency in accordance with accepted medical practice to treat that illness or injury; (3) not solely for the participant's convenience or the convenience of the physician, hospital or other health care provider; (4) the most appropriate health care service or location for providing such health care service, which can be safely provided to the participant and accomplishes the desired end result in the most economical manner; and (5) supported by information contained in the participant's medical records or from other relevant sources.

Medical Services: professional services recognized by a physician in the treatment of illness or injury and directly provided to a participant. Not included are: maternity services; surgery; anesthesiology; pathology; and radiology.

Medical Supplies: items which are, as determined by the Claim Administrator: (1) used primarily to treat an illness or injury; (2) generally not useful to a person in the absence of an illness or injury; (3) the most appropriate item which can be safely provided to a participant and accomplish the desired end result in the most economical manner; and (4) prescribed by a physician. The item's primary function must not be for the patient's comfort or convenience.

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

Miscellaneous Hospital Expense: the charges for regular hospital expenses (but not room and board, nursing services, and ambulance services) covered under the Plan for treatment of an illness or injury requiring either inpatient hospitalization or outpatient health care services at a hospital. For outpatient health care services, this includes charges for use of the hospital's emergency room and for emergency medical care provided to a participant at the hospital. Miscellaneous hospital expenses include take-home drugs.

Morbid Obesity/Morbidly Obese: when a participant's Body Mass Index (BMI): (1) is 35 or above for participants who are age 19 and over; or (2) falls above the 85th percentile on the growth chart of participants who are less than 19 years old. Body Mass Index is defined as the participant's weight in kilograms divided by the square of their height in meters. A physician must define morbid obesity utilizing the method stated in this definition.

Nervous or Mental Disorders: a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within one of the following classification categories or codes: 295 - Schizophrenic Disorders; 296 - Episodic Mood Disorders; 297 - Delusional Disorders; 298 - Other Nonorganic Psychoses; 300 - Anxiety, Dissociative and Somatoform Disorders; 301 - Personality Disorders; 302 - Sexual and Gender Identity Disorders; 306 - Physiological Malfunction Arising From Mental Factors; 307 - Special Symptoms or Syndromes, Not Elsewhere Classified; 308 - Acute Reaction to Stress; 309 - Adjustment Reaction; 311 - Depressive Disorder, Not Elsewhere Classified; 312 - Disturbance of Conduct, Not Elsewhere Classified; 313 - Overanxious Disorder; and 314 - Hyperkinetic Syndrome of Childhood.

New Entrant: an eligible employee, or dependent of an eligible employee, who:

1. becomes part of the employer group after the commencement of the employer's initial enrollment period under the Plan. A new entrant must enroll for coverage under the Plan within 30 days immediately following the end of his/her probationary period;

2. is a spouse or dependent child who a court orders be covered under the Plan and who requests enrollment under the Plan;

3. failed to request coverage under the Plan during an enrollment period, during which the person was entitled to enroll under the Plan, if the person:

- **a.** was covered under creditable prior coverage at the time of the initial enrollment period; and
- **b.** loses his/her creditable prior coverage involuntarily; and
- **c.** requests enrollment under the Plan within 30 days immediately following the voluntary or involuntary loss of his/her creditable prior coverage; or
- **d.** requests enrollment under the Plan within 60 days after the loss of eligibility for Medicaid, including BadgerCare Plus; or
- **e.** requests enrollment under the Plan within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, has been determined; and
- **f.** states, at the time of enrollment, that coverage under another health benefit plan was the reason for declining enrollment; or

4. a person who is employed by an employer who offers multiple health benefit plans and the person elects a different health benefit plan during an open enrollment period.

Nurse Practitioner: an individual who is licensed as a registered nurse under Chapter 441, Wisconsin Statutes, as amended, or the laws and regulations of another state and who satisfies any of the following: (1) is certified as a primary care nurse practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; (2) holds a master's degree in nursing from an accredited school of nursing; (3) prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least four months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program; or (4) has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of (3) above, and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

Office Visit:

1. for health care services other than health care services for treatment of nervous or mental disorders, drug and alcohol abuse, office visit means a participant's meeting with a physician or other health care provider at the physician's office or convenient care clinic. During that meeting you must receive from the physician or other health care provider: (1) medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology); or (2) manipulations by a physician, other than services related to physical therapy.

2. for health care services for treatment of nervous or mental disorders, drug and alcohol abuse, office visit means a participant's meeting with a licensed psychiatrist, a licensed or certified psychologist, or a health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse in the provider's office. During that meeting you must receive: (a) psychotherapy; (b) psychiatric diagnostic interviews; (c) medication management; (d) electro-shock therapy; (e) behavioral counseling; or (f) neuropsychological testing.

Outpatient Treatment Facility: a facility licensed or approved by the Department. Its outpatient services must meet the Department's standards. It must provide the following outpatient services to prevent and treat an illness: (1) comprehensive diagnostic and evaluation services; (2) outpatient care and treatment, precare, aftercare, emergency care, rehabilitation and habilitation, and supportive transitional services; and (3) professional consultation.

Participant: a covered employee or one of his/her covered dependents.

Physical Illness: a disturbance in a function, structure or system of the human body which causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of the health state of the function, structure or system of the human body. Physical illness includes pregnancy and complications of pregnancy. Physical illness does not include alcoholism, drug abuse, or a nervous or mental disorder.

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

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

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

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

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

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

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

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

When required by law to cover the health care services of any other licensed medical professional under the Plan, a physician also includes such other licensed medical professional who: (1) is licensed by the state in which he/she is located; (2) is acting within the lawful scope of his/her license; and (3) provides a health care service which the Claim Administrator determines is a covered expense under the Plan. A physician does not include a chiropractor.

Psychologist: a person who: (1) has received a doctoral degree in psychology from an accredited college or university; and (2) is licensed by the state in which he/she is located; and (3) provides health care services while he/she is acting within the lawful scope of his/her license. A psychologist is limited to the following:

1. Doctor of Philosophy (Ph. D.); or

2. Doctor of Psychology (Psy. D.).

A doctoral degree in psychology means a doctoral degree in a study which involves the application of principles of the practice of psychology that is recognized by the American Psychological Association.

Reconstructive Surgery: surgery performed on abnormal structures of the body, caused by congenital defects, development abnormalities, trauma, infection, tumors or disease. The presence of a psychological condition alone will not entitle a participant to coverage for plastic or reconstructive surgery.

Retiree: see subsection "Eligible Retiree" of section "ELIGIBILITY AND COVERAGE" for retiree eligibility.

Services: hospital services, professional services, surgical services, maternity services, medical services or any other service directly provided to a participant by a health care provider, as determined by the Claim Administrator.

Single Coverage: means coverage applies only to a covered employee.

Skilled Nursing Care: health care services furnished on a physician's orders which requires the skills of professional personnel such as a registered nurse or a licensed practical nurse and is provided either directly by or under the direct supervision of such professional personnel.

Sound Natural Teeth: teeth that: (1) are organic and formed by the natural development of the human body; (2) are not manufactured; (3) have not been extensively restored; (4) have not become extensively decayed or involved in periodontal disease; and (5) are not more susceptible to injury than whole natural teeth.

Supplies: medical supplies, durable medical equipment or other supplies directly provided to a participant by a health care provider, as determined by the Claim Administrator.

Supportive Care: Supportive care is health care services provided to a participant whose recovery has slowed or ceased entirely, and only minimal rehabilitative gains can be demonstrated with continuation of such health care services.

Surgical Services: an operative procedure performed by a physician and that is recognized by the Claim Administrator for the treatment of an illness or injury. Such services include sterilization procedures, preoperative and postoperative care. Such services don't include the reversal of a sterilization procedure, oral surgical services and maternity services.

Totally Disabled/Total Disability: this means an employee is unable due to illness or injury to perform the essential functions of any full-time job with the Employer, as determined by the Claim Administrator. The employee is not totally disabled if he/she is working on either a full-time or part-time basis for wage or profit for anyone, including working for himself/herself. For dependents, this means the person's inability due to illness or injury to carry on most of the normal activities of a person of the same age and sex, including, but not limited to, being unable to work on either a full-time or part-time basis for wage or profit for anyone, including working for himself/herself, as determined by the Claim Administrator. The totally disabled person must be under the regular care of a physician. The Claim Administrator has the right to examine such person, including having health care providers examine that person, as often as reasonably requires to determine whether or not that person is totally disabled.

Treatment: management and care directly provided to a participant by a physician or other health care provider for the diagnosis, remedy, therapy, combating, or the combination thereof, of an illness or injury, as determined by the Claim Administrator.

We, Us, Our: the Claim Administrator.

You, Your: a participant.

ELIGIBILITY AND COVERAGE

Eligible Employees

An eligible employee is a person who:

1. appears on the Employer's regular payroll records (excluding employees working on a temporary or substitute basis); and

2. performs all of the duties of his/her principal occupation in his/her job with the Employer for at least 20 hours per week.

An employee is eligible for coverage under the Plan if he/she:

1. is actively at work performing all of the duties of his/her principal occupation in his/her job with the Employer and paid at least the minimum wage required by law for at least 20 hours per week; and

2. is actively performing all such duties on the effective date of his/her coverage under the Plan; and

Eligible Dependent

An eligible dependent is a person who is:

1. a covered employee's lawful spouse;

2. a covered employee's natural child, adopted child, child placed for adoption with the covered employee, step-child or legal ward who is less than age 26;

3. a covered employee's unmarried natural child, adopted child, child placed for adoption with the employee, step-child or legal ward who is age 26 and meets the following criteria:

4. a covered employee's child who is a full-time student as defined in the Plan;

5. an unmarried natural child of a dependent child (as described in (2) above) until the dependent child is 18 years of age;

In the case of a child placed for adoption with the covered employee, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended.

A person is not an eligible dependent if he/she is:

1. a child and such child is eligible under a group health benefit plan as an employee and the amount of the child's premium contribution is less than the premium amount for his/her coverage as a dependent under the Plan;

2 on active duty with the military service, including national guard or reserves, other than for duty of less than 30 days; or

3. a child if such child is no longer eligible if adopted or placed for adoption and insured under the adopting person's coverage in accordance with Section 632.896, Wisconsin Statutes, as amended.

No person shall be considered as an eligible dependent of more than one employee covered as a covered employee under the Plan.

An unmarried dependent child who is over the age of 27 may remain covered as a dependent under the Plan if he/she meets certain requirements, provided the covered employee's family coverage remains in force under the Plan. The child must:

1. be unable to support himself/herself with a job because of mental retardation or physical handicap;

2. have become totally disabled before he/she reaches the age of 27; and

3. be principally supported by the covered employee.

Written proof of the child's totally disabling condition must be given to the Claim Administrator within 31 days of the child attaining age 27. Failure to provide such proof to us within that 31-day period shall result in the termination of that dependent child's coverage in accordance with section "WHEN COVERAGE ENDS."

Eligible Retiree

A covered employee who retires who has at least 20 years of services with the Employer and qualifies for full WRS retirement benefits.

Enrollment Period

The enrollment period for an eligible employee is the 31-day period beginning immediately following an eligible employee's date of hire. The enrollment period for an eligible dependent is the period beginning immediately following the dependent's eligibility date through the 31st day following the dependent's eligibility date.

Effective Date

1. **New Entrants.**

An eligible employee shall become covered under the Plan (eligibility date) on his/her date of hire. An eligible dependent shall become covered under the Plan as of his/her eligibility date. In both cases, the employee must request single or family coverage under the Plan within 31 days after: (a) the employee's eligibility date; or (b) the

date the dependent becomes eligible, provided the employee has applied for family coverage under the Plan. If the application is submitted to us after his/her enrollment period ends, that employee and/or his/her dependents, if any, are late enrollees and will not be covered under the Plan. Please see paragraph 2. below.

However, if an otherwise eligible employee is not actively at work with the Employer for any reason, other than for any health reason, on the date his/her coverage would otherwise become effective under the Plan, his/her single or family coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the Employer.

2. Late Enrollees.

A late enrollee (as defined in the Plan) may apply only during the annual enrollment period specified by the Employer. If the late enrollee applies for coverage during this period, his/her effective date of coverage under the Plan will be the following August 1.

Completed enrollment forms must be received by the Employer before the end of the annual open enrollment period. If the late enrollee fails to apply during the annual enrollment period, he/she will not be covered unless he/she applies during the next annual enrollment period.

3. Change in Marital Status.

a. **Changing From Single Coverage to Family Coverage Due to Marriage.** If a covered employee has single coverage and wishes to change to family coverage to add an eligible spouse due to his/her marriage, the covered employee must apply for coverage within 31 days of the date of his/her marriage. The effective date of family coverage will be the date of the marriage. If application is submitted to us after that 31-day period ends, the eligible spouse is a late enrollee. Please see paragraph 2. above.

b. **Applying For Coverage Due to Marriage.** If an eligible employee wishes to apply for family coverage to add himself/herself and eligible dependent(s) due to his/her marriage, the eligible employee and/or eligible dependents must apply for coverage within 31 days of the date of marriage. The effective date of family coverage will be the date of the marriage. If application is submitted to us after that 31-day period ends, the eligible employee and his/her eligible dependents are late enrollees. Please see paragraph 2. above.

4. Adding a Newborn Natural Child.

a. **Adding Newborn Natural Children to Existing Family Coverage.** If a covered employee has family coverage, coverage is provided for his/her newborn natural child from the moment of that child's birth. Within 31 days of birth, the covered employee must complete an enrollment form adding the newborn natural child to his/her existing coverage.

b. **Changing From Single Coverage to Family Coverage to Add a Newborn Natural Child.** If a covered employee has single coverage, coverage is provided for his/her newborn natural child from the moment of that child's birth and for the next 60 days of that child's life immediately following that child's date of birth. Prior to the end of that 60-day period, the covered employee must apply for family coverage as described below. If the covered employee fails to apply for family coverage as stated below, coverage for his/her newborn natural child shall terminate at the end of that child's 60-day period.

If a covered employee wishes to change to family coverage to add his/her newborn natural child, he/she must apply to us for coverage within the first 60 days after the birth of his/her natural child. The effective date for such family coverage will be the date of that child's birth. If application is submitted to us after that 60-day period ends, the eligible employee's newborn natural child is a late enrollee. Please see paragraph 2. above.

c. **Applying For Coverage Due to the Birth of a Newborn Child.** If an eligible employee wishes to apply for family coverage to add himself/herself and his/her other eligible dependents due to the birth of his/her natural child, the eligible employee and/or his/her eligible dependents must apply for coverage within 31 days of the birth of the newborn natural child. The effective date of family coverage shall be the date of birth of the newborn natural child. If application is submitted to us after that 31-day period ends, the eligible employee and/or his/her eligible dependents are late enrollees. Please see paragraph 2. above.

5. **Adding an Adopted Child.**

   a. **Adding an Adopted Child to Existing Family Coverage.** If a covered employee has family coverage, coverage is provided for his/her adopted child: (1) on the date a court makes a final order granting adoption of the child by the covered employee; or (2) on the date that the child is placed for adoption with the covered employee, whichever occurs first.

   b. **Changing From Single Coverage to Family Coverage to Add a New Eligible Dependent Because of Adoption.** If a covered employee has single coverage and wishes to change his/her coverage to add a new eligible dependent because of his/her adoption of a child or a child placed for adoption, the covered employee must apply for coverage within 60 days of the date of such adoption or placement for adoption. In the case of a child placed for adoption with the covered employee, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended. If the covered employee applies within that 31-day period, the effective date for such new coverage will be: (1) on the date a court makes a final order granting adoption of the child by the covered employee; or (2) on the date that the child is placed for adoption with the covered employee, whichever occurs first. If the covered employee applies to the Employer after that 60-day period, his/her new dependent is a late enrollee. Please see paragraph 2. above.

      If adoption of a child who is placed for adoption with the covered employee is not finalized, the child's coverage will terminate when the child's adoptive placement with the covered employee terminates.

   c. **Applying for Coverage Due to Adoption.** If an eligible employee wishes to apply for family coverage to add himself/herself and his/her other eligible dependents due to the adoption or placement for adoption of a child with the eligible employee, the eligible employee and/or his/her eligible dependents must apply for coverage within 31 days of the adoption or placement for adoption of the child. The effective date of family coverage shall be on the date a court makes a final order granting adoption of the child by the eligible employee or on the date that the child is placed for adoption with the eligible employee, whichever occurs first. If application is submitted to us after that 31-day period ends, the eligible employee and/or his/her eligible dependents are late enrollees. Please see paragraph 2. above.

6. **Addition of Dependents.**

   If a covered employee wishes to add any dependents under his/her family coverage who were not covered previously under the Plan (other than as described in paragraphs 3. through 6. above), such additional dependents will be effective on the date the dependent becomes eligible, provided the employee has applied for family coverage under the Plan and applies to the Claim Administrator within 31 days of the dependent's eligibility date. However, if the application is submitted to us after the 31-day period stated above, that dependent will be considered a late enrollee. Please see paragraph 2. above.

7. **Eligible Retirees.**

   If you meet the definition as an eligible retiree, you have the option of continuing coverage under the Plan. This option is in addition to your rights to continuation coverage required by state and federal law.

ANNUAL DEDUCTIBLE AND COPAYMENT AMOUNTS

Annual Deductible Amounts

The annual deductible amounts are shown in the Schedule of Benefits. The annual deductible amount applies each calendar year. Charges for covered expenses for health care services directly provided to a participant must add up to the appropriate deductible amount before benefits are payable for other charges for covered expenses. No benefits are payable for the charges used to satisfy a participant's deductible amount. The participant is responsible for paying the charges used to satisfy the appropriate deductible amount.

The deductibles under the preferred provider benefits and all other provider benefits are combined.

Charges incurred in the last three months of a calendar year which are applied to any deductible for that calendar year are carried over and applied toward the deductible amount for the following calendar year. The deductible carryover amount does not apply to the out-of-pocket limit for the following calendar year.

Home or Office Visit Copayment

This subseciton only applies to home and office visits that are billed as emergency medical care.

The home or office visit copayment amount is shown in the Schedule of Benefits. The copayment amount applies to the physician's charge for each home or office visit by a physician or other health care provider. The copayment does not apply to charges billed by a facility (for example, a hospital) for an office visit. Those charges shall be subject to the applicable annual deductible amount and coinsurance.

The copayment amount applies to each home or office visit by a physician or other health care provider with the participant. For each participant, charges for covered expenses must add up to the copayment amount before benefits are payable for charges for the covered expenses for that home or office visit. No benefits are payable for the charges used to satisfy the participant's copayment amount. The participant is responsible for paying the charges used to satisfy the appropriate copayment amount.

The annual deductible amounts do not apply to those home or office visits.

Hospital Emergency Room Visit Copayment

The copayment amount for a participant's use of a hospital emergency room is shown in the Schedule of Benefits. The copayment amount applies to each participant for each visit to the hospital emergency room. For each participant, charges for covered expenses must add up to the copayment amount benefits are payable for charges for health care services provided during the emergency room visit. No benefits are payable for the charges used to satisfy a participant's copayment amount. The participant is responsible for paying the charges used to satisfy the appropriate copayment amount.

The hospital emergency room copayment will be waived for that visit if the participant is admitted as a resident patient to the hospital directly from the hospital emergency room.

The annual deductible amounts do not apply to hospital emergency room visits.

COINSURANCE

After the deductible amount is satisfied, benefits are payable for charges for the covered expenses for health care services directly provided to a participant at the coinsurance percentage shown in the Schedule of Benefits, unless specifically stated otherwise in the Plan, up to the annual out-of-pocket limit stated below.

ANNUAL OUT-OF-POCKET LIMIT

The annual out-of-pocket limit for covered expenses for health care services directly provided to a participant is shown in the Schedule of Benefits. This total is made up of the deductible, copayments and coinsurance amounts which a participant pays for covered expenses for health care services directly provided to the participant in one calendar year.

The out-of-pocket limits under the preferred provider benefits and all other provider benefits are combined.

The out-of-pocket limits do not include: (1) the coinsurance amounts for surgical services related to a covered transplant; and (2) any reductions in benefits otherwise payable for failure to comply with: (a) preadmission and continued stay certification requirements shown in subsection "Preadmission Certifications" and (b) prior approval requirements shown in subsection "Prior Approval of Health Care Services". No benefits are payable for charges used to satisfy the annual out-of-pocket limit, including your annual deductible amount, coinsurance and copayment amounts. You are responsible for paying the charges used to satisfy the appropriate deductible, coinsurance and copayment amounts.

After the applicable annual out-of-pocket limit is reached, benefits are payable at 100% of the charges for covered expenses, unless specifically stated otherwise in the Plan, incurred by the participant during the remainder of the calendar year, subject to the annual maximum benefit limit and all other limitations, terms, conditions and provisions of the Plan.

ANNUAL MAXIMUM BENEFIT LIMIT

The annual maximum benefit limit is the total amount of benefits payable for all covered illnesses and injuries for each participant each calendar year and is shown in the Schedule of Benefits. The participant annual maximum benefit limit applies to all covered expenses incurred during the calendar year while that participant is covered under the Plan. No benefits are payable for expenses incurred for treatment, services or supplies provided to a participant either before that participant's effective date of coverage under the Plan or after that participant's coverage has terminated under the Plan. Please see section "TERMINATION OF COVERAGE". In no event will the Plan pay more than the participant annual maximum benefit limit.

COVERED EXPENSES

The following health care services are covered expenses. All health care services:

1. Must be medically necessary;

2. Must be ordered by a physician for a covered illness, covered injury, or for preventive care;

3. Must be provided by:

- **a.** a physician of your choice to treat your illness or injury. A physician shall include a registered nurse or licensed practical nurse, laboratory/x-ray technician and physician assistant, provided such person is lawfully employed by the supervising physician or the facility where the service is provided and he/she provides an integral part of the supervising physician's health care services while the physician is present in the facility where the health care service is provided. With respect to such health care services provided by a registered nurse or licensed practical nurse, laboratory/x-ray technician and physician assistant, such health care services must be billed by the supervising physician or the facility where the service is performed; or
- **b.** a nurse practitioner, a physician assistant or a physician providing health care services at a convenient care clinic; or
- **c.** any other health care provider licensed to provide a health care service covered under the Plan, unless specifically stated otherwise in the Plan.

If the health care service is not listed in this section, that health care service is not covered and benefits are not payable under the Plan.

Benefits are not payable for maintenance care, custodial care, supportive care, or any health care service to which an exclusion applies. Please see section "GENERAL EXCLUSIONS".

Benefits are payable for charges for the following health care services:

Acupuncture Therapy

Acupuncture therapy for adult (participants 18 and over) postoperative nausea and vomiting, chemotherapy nausea and vomiting, and postoperative dental pain.

Alcoholism Treatment

See subsection "Nervous or Mental, Drug and Alcohol Treatment" for benefits for alcoholism treatment.

Allergy Testing and Treatment

Allergy testing and treatment approved by the American Academy of Allergy, Asthma and Immunology (AAAAI).

Benefits are not payable for the following therapy and testing for treatment of allergies, unless approved by the American Academy of Allergy, Asthma and Immunology (AAAAI):

1. services related to clinical ecology, environmental allergy, and allergic immune system dysregulation;

2. sublingual antigen(s);

3. RAST tests;

4. extracts;

5. neutralization tests and/or treatment.

Alternate Care

Sometimes your attending physician may advise you to consider an alternative course of treatment or confinement for a covered illness or injury which differs from your current course of treatment or confinement for that covered illness or injury and includes health care services not covered under the Plan. Your attending physician should contact us so we can discuss it with him/her. We, at our option, will consider paying benefits under the Plan for charges for such health care services as long as such health care services are medically necessary to treat your illness or injury. Payment of benefits, if any, shall be made as determined by us, at our option. We may consider an alternative care plan if the alternative care is not subject to an exclusion of the Plan and it appears that:

1. the recommended alternative course of treatment or confinement offers a medical therapeutic value at least equal to the current treatment or confinement;

2. the current course of treatment or confinement may be changed without jeopardizing your health; and

3. the charges incurred for health care services to be provided under the alternative course of treatment or confinement to its end will be less than those charges for health care services to be provided under the current course of treatment or confinement to its end.

The alternative care decision, if any, will be made by us on a case by case basis and does not set precedent for future claims.

Any alternative care decision must be approved by us, you and the attending physician before your alternative course of treatment or confinement begins. Any additional treatment or confinement beyond the agreed to alternative course of treatment or confinement must be reviewed and reconsidered by us and approved by us, you and the attending physician.

We'll send a letter to you and your attending physician. This letter will provide:

1. the alternative course of treatment or confinement;

2. the projected costs for such treatment or confinement; and

3. the benefits payable by us for charges incurred for such course of treatment or confinement.

The benefits payable by us will first be paid as provided under the Plan. In the event that the alternative course of treatment or confinement includes health care services not covered under the Plan, we, at our option, will consider paying benefits under the Plan for charges for such health care services as long as such health care services are medically necessary and the original course of treatment would have been covered under the Plan to treat your covered illness or injury. Payment of benefits, if any, shall be made as determined by us, at our option.

Ambulance Services

Ambulance services are ground and air transportation provided by a licensed professional ambulance service using its licensed and or/certified vehicle, helicopter, or plane which is designed, equipped, and used to transport you when you are sick or injured and which is staffed by emergency medical technicians, paramedics, or other certified medical professionals:

1. From your home or the scene of an accident or medical emergency to a hospital;

2. Between hospitals;

3. Between a hospital and a skilled nursing facility; or

4. From a hospital or a skilled nursing facility to your home.

Ambulance services include emergency medical care directly provided to you during your ambulance transport which is included within the fees billed by the licensed professional ambulance service for its ambulance services. The emergency medical care for which fees are billed separately by the licensed professional ambulance service from the fees billed by the

licensed professional ambulance service for the ambulance services shall be payable as stated elsewhere in the applicable terms, conditions and provisions of the Plan.

Ambulance transports must be made to the closest local facility that can provide health care services appropriate for your illness or injury, as determined by us. If none of these facilities are located in your local area, you are covered for transports to the closest facility outside your local area. Benefits are not payable for ambulance services:

1. When another type of transportation can be used by you without endangering your health;

2. For any transportation for the personal convenience of you, a family member, physician, or other health care provider;

3. For any transportation undertaken to secure your treatment by a personal physician or by a physician or institution of greater renown or greater specialization is not covered; and

4. For any transportation provided by anyone other than a licensed professional ambulance service.

Our prior approval is recommended for non-emergency licensed professional ambulance services to transport you from a hospital or other health care facility to another hospital or health care facility. If you do not receive our prior approval, benefits for such services may not payable under the Plan and such services may not covered.

Anesthesia Services

Anesthesia services provided in connection with other health care services covered under the Plan.

Autism Services

1. **Definitions.** The following definitions apply to this paragraph only:

Autism Spectrum Disorder: any of the following: (a) autism disorder; (b) Asperger's syndrome; or (c) pervasive developmental disorder not otherwise specified.

Behavior Analyst: a person who is certified by the Behavior Analyst Certification Board, Inc., or successor organization, as a board-certified behavior analyst and has been granted a license under 440.312, Stats, to engage in the practice of behavior analysis.

Behavioral: interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

Department: the Wisconsin Department of Health Services.

Evidence-based Therapy: therapy that is based upon medical and scientific evidence and is determined to be an efficacious treatment or strategy and is prescribed to improve the participant's condition or to achieve social, cognitive, communicative, self-care or behavioral goals that are clearly defined within the participant's treatment plan.

Efficacious Treatment or Efficacious Strategy: treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive-level services; or to improve a participant with autism spectrum disorder's condition.

Intensive-level Service: evidenced-based behavioral therapies that are directly based on, and related to, a participant's therapeutic goals and skills as prescribed by a physician familiar with the participant. Intensive level service may include evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, a participant's therapeutic goals and skills, and is concomitant with evidence-based behavioral therapy.

Nonintensive-level Services: evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy what will improve the individual's condition.

Practice of Behavior Analysis: the design, implementation, and evaluation of systematic instructional and environmental modifications to produce socially significant improvements in human behavior, including the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis, including interventions based on scientific research and the direct observation and measurement of behavior and environment. Practice of behavior analysis does not include psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, marriage counseling, psychoanalysis, hypnotherapy, and long-term counseling as treatment modalities.

Qualified Intensive-level Professional: an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and who has completed at least 2,080 hours of training, education and experience including all of the following:

a. 1,500 hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models;

b. supervised experience with all of the following:

- **(1)** working with families as part of a treatment team and ensuring treatment compliance;
- **(2)** treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
- **(3)** treating individuals with autism spectrum disorders with a variety of behavioral challenges;
- **(4)** treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and

c. academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

Qualified Intensive-level Provider: an individual identified in s. 632.895 (12m) (b) 1. to 3m., Stats., respectively, acting within the scope of a currently valid state-issued license for psychiatry, psychology or behavior analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy, who provides evidence-based behavioral therapy in accordance with this section and s. 632.895 (12m) (a) 3., Stats., and who has completed at least 2080 hours of training, education and experience which includes all of the following:

a. 1,500 hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models;

b. supervised experience with all of the following:

- **(1)** working with families as the primary provider and ensuring treatment compliance;
- **(2)** treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
- **(3)** treating individuals with autism spectrum disorders with a variety of behavioral challenges;
- **(4)** treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and
- **(5)** designing and implementing progressive treatment programs for individuals with autism spectrum disorders; and

c. academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

Qualified Paraprofessional: an individual working under the active supervision of a qualified supervising provider, qualified intensive-level provider or qualified provider and who complies with all of the following:

a. attains at least 18 years of age;

b. obtains a high school diploma;

c. completes a criminal background check;

d. obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid;

e. obtains at least 10 hours of training in the use of behavioral evidence-based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present;

f. receives regular, scheduled oversight by a qualified provider in implementing the treatment plan for the participant.

Qualified Professional: a professional working under the supervision of an outpatient mental health clinic certified under s. 51.038 Stats., acting within the scope of a currently valid state-issued license and who provides evidence-based therapy.

Qualified Provider: an individual identified under s. 632.895 (12m) (b) 1. to 3m., Stats., acting within the scope of a currently valid state-issued license for psychiatry, psychology, behavior analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy and who provides evidence-based therapy as defined above and in accordance with this provision.

Qualified Supervising Provider: a qualified intensive-level provider and who has completed at least 4,160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

Qualified Therapist: a speech-language pathologist or occupational therapist acting within the scope of a currently valid state issued license and who provides evidence-based therapy.

Supervision of an Outpatient Mental Health Clinic: an individual who meets the requirements of a qualified supervising provider and who periodically reviews all treatment plans developed by qualified professionals for participants with autism spectrum disorder.

Waiver Program: services provided by the department through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare & Medicaid Services.

2. **Benefits.** Benefits are payable for charges for covered expenses as described in this paragraph for participants who have a verified diagnosis of autism spectrum disorder, as determined by us. Services must be prescribed by a physician and provided by any of the following who are qualified to provide intensive level services or nonintensive-level services: (a) a qualified provider; (b) a qualified paraprofessional under the supervision of a qualified supervising provider; (c) a qualified professional; or (d) a qualified therapist.

The benefits under this paragraph do not include benefits for durable medical equipment and prescription legend drugs.

Benefits are payable for the following:

a. **Intensive-Level Services.** We'll pay benefits for charges for intensive-level services, the majority of which shall be provided to the participant when the parent or legal guardian is present and engaged and all of the prescribed intensive-level services must meet all of the following requirements:

(1) be based upon a treatment plan developed by a qualified provider that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the participant be present and engaged in the intervention. We may request and review the participant's treatment plan and the summary of progress on a periodic basis;

(2) implemented by qualified providers, qualified professionals, qualified therapists or qualified paraprofessionals;

(3) provided in an environment most conducive to achieving the goals of the participant's treatment plan;

(4) implemented identified therapeutic goals by the team including training and consultation, participation in team meetings and active involvement of the participant's family;

(5) begin after a participant is two years of age and before the participant is nine years of age; and

(6) provided by a qualified intensive-level provider or qualified intensive-level professional who directly observes the participant at least once every two months.

Benefits are payable for up to 48 months of intensive-level services during a participant's lifetime, subject to a maximum benefit limit of $50,000 per participant per calendar year. The 48 month lifetime maximum will be reduced by any previous length of time during which the participant received intensive-level services.

Benefits are also payable for charges of a qualified therapist when rendered concomitant with intensive-level evidence-based behavioral therapy and all of the following: (i) the qualified therapist provides evidence-based therapy to a participant who has a primary diagnosis of autism spectrum disorder; (ii) the participant is actively receiving behavioral services from a qualified intensive-level provider or qualified intensive-level professional; (iii) the qualified therapist develops and implements a treatment plan consistent with their license.

b. **Nonintensive-Level Services.** We'll pay benefits for charges for nonintensive-level therapy services that are evidenced-based provided to a participant by a qualified provider, qualified professional, qualified therapist or qualified paraprofessional in either of the following conditions:

(1) after the completion of intensive-level services and designed to sustain and maximize grains made during intensive-level services treatment; or

(2) to a participant who has not and will not receive intensive-level services but for whom nonintensive-level services will improve the participant's condition.

All nonintensive level services must meet all of the following requirements:

(1) be based upon a treatment plan developed by a qualified provider, a qualified professional or qualified therapist that includes specific evidence-based therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the participant be present and engaged in the intervention. We may request and review the participant's treatment plan and the summary of progress on a periodic basis;

(2) implemented by a person who is at least a qualified provider, qualified professional, qualified therapist or qualified paraprofessional;

(3) provided in an environment most conducive to achieving the goals of the participant's treatment plan;

(4) implemented identified therapeutic goals developed by the team including training and consultation, participation in team meetings and active involvement of the participant's family.

Benefits are payable up to a benefit maximum of $25,000 per participant per calendar year for nonintensive-level services.

3. **Transition from Intensive-Level Services to Nonintensive-Level Services.** We shall provide a participant, or his/her authorized representative, of the change in a participant's level of treatment. The notice shall indicate the reason for the transition that may include any of the following:

a. the participant has received 48 cumulative months of intensive-level services;

b. the participant no longer requires intensive-level services as supported by documentation from a qualified intensive-level provider, qualified intensive-level professional or a qualified supervising provider; or

c. the participant no longer receives evidence-based therapy for at least 20 hours per week over a six month period of time.

The participant, or his/her representative should notify us if he/she is unable to receive intensive-level services for an extended period of time. The notification must indicate the specific reason or reasons the participant or the participant's family or care giver are unable to comply with an intensive-level service treatment plan. Reasons for requesting intensive-level services be interrupted for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason acceptable to us. We will not deny intensive-level services to a participant for failing to maintain at least 20 hours per week of evidence based behavioral therapy over a six-month period when: (a) the participant notifies us as stated above; or (b) the

participant, or his/her authorized representative, can document that the participant failed to maintain at least 20 hours per week of evidence-based behavioral therapy due to waiting for waiver program services.

4. **Exclusions.** This subsection is not subject to the exclusions in section "GENERAL EXCLUSIONS." This subsection is subject to the following exclusions. The Plan provides no benefits for:

- **a.** acupuncture;
- **b.** animal-based therapy including hippotherapy;
- **c.** auditory integration training;
- **d.** chelation therapy;
- **e.** child care fees;
- **f.** cranial sacral therapy;
- **g.** hyperbaric oxygen therapy;
- **h.** custodial or respite care;
- **i.** special diets or supplements;
- **j.** travel time by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals;
- **k.** therapy, treatment or services when provided to a participant who is residing in a residential treatment center, inpatient treatment or day treatment facility;
- **l.** costs for the facility or location or for the use of a facility or location when treatment, therapy or services are provided outside of a participant's home;
- **m.** claims that have been determined by us to be fraudulent; and
- **n.** treatment provided by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessionals for treatment provided to their own children.

Blood and Blood Plasma

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

Cardiac Rehabilitation Services

Outpatient cardiac rehabilitation services directly provided to you in a facility with a facility-approved cardiac rehabilitation program. This coverage applies only to a participant with a recent history of:

1. a heart attack (myocardial infarction);
2. coronary bypass surgery;
3. onset of angina pectoris;
4. onset of unstable angina;
5. onset of decubital angina;
6. heart valve surgery;
7. percutaneous transluminal angioplasty; or
8. another condition for which we determine cardiac rehabilitation as being appropriate for treating your medical condition.

Benefits are payable only for an eligible participant who begins an outpatient exercise program following his/her discharge from a hospital. Benefits are payable for charges for up to 48 supervised and monitored exercise sessions per covered illness starting with the first session in the outpatient exercise program.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under the Plan.

Chiropractic Services

Benefits are payable for chiropractic services for rehabilitative care, provided to diagnose and treat acute neuromuscular-skeletal conditions.

Massage therapy which is performed in conjunction with other treatment/modalities by a chiropractor and is part of a prescribed treatment plan and is not billed separately is covered under the Plan.

Contraceptives for Birth Control

Devices or medications used as contraceptives which require a prescription or intervention by a physician or other licensed health care provider, including related health care services. Examples include:

1. Intrauterine devices (IUD);

2. Subdermal contraceptive implants;

3. Diaphragms;

4. Injections of medication for birth control.

Benefits are not payable for contraceptive devices or supplies which can be obtained without intervention by a physician or other licensed health care provider including, but not limited to, condoms and contraceptive foam or gel.

Dental Services

Dental services, limited to the following:

1. dental repair of your sound natural teeth due to an injury, provided treatment begins within six months of the injury. When an implant-supported dental prosthetic treatment is pursued, benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment;

2. extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease;

3. sealants on existing teeth to prepare the jaw for chemotherapy treatment of neoplastic disease;

4. extraction of teeth in preparation for a covered transplant;

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

6. treatment of cleft lip and cleft palate of a covered dependent child, including orthodontic treatment and oral surgery directly related to the cleft. Benefits for participants age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not necessary for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services.

7. extraction of natural teeth and initial replacement of natural teeth;

8. replacement of previously existing partial removable dentures or fixed bridgework if replacement is required by reason of the extraction of one or more natural teeth.

Diabetes Treatment

Benefits are payable for charges incurred for the installation and use of an insulin infusion pump, and all other equipment and supplies used in the treatment of diabetes, including insulin, insulin syringes and needles, lancets, diabetic test strips, alcohol pads, dextrose (tablets and gel), auto injector, auto blood sampler, and glucose control solution.

This benefit is limited to the purchase of one pump per participant per calendar year. You must use the pump for at least 30 days before the pump is purchased. We'll also pay benefits for charges for diabetic self-management education programs, but only if the program is medically necessary, as determined by us.

Diagnostic Services

We'll pay benefits for charges for diagnostic x-rays, radiology and laboratory services directly provided to you for radiology and lab tests related to covered physical illness or injury.

Drug Abuse Treatment

See subsection "Nervous or Mental, Drug and Alcohol Treatment" for benefits for drug abuse treatment.

Durable Medical Equipment

Rental of or, at our option, purchase of durable medical equipment. The equipment must be prescribed by a physician. Durable medical equipment includes, but is not limited to: wheelchairs; hospital-type beds; and artificial respiration equipment; oxygen equipment, including oxygen. Coverage for such equipment and devices will be limited to the standard models as determined by us. You are responsible for paying any amount in excess of the charge for the standard models. When the durable medical equipment is purchased, benefits are payable for subsequent repairs necessary to restore the durable medical equipment to a serviceable condition. If the durable medical equipment is rented, we'll pay benefits for charges up to the purchase price of that durable medical equipment. Rental fees exceeding the purchase price, routine periodic maintenance, and replacement of batteries are not covered, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of one month rental billed every six months.

Our prior approval is required for any durable medical equipment that will be rented for more than three months or with a total purchase price greater than $3,000. If you do not receive our prior approval in accordance with subsection "Prior Approval of Health Care Services", benefits for such durable medical equipment will be reduced by 20% of the charges for covered expenses.

Genetic Services

Genetic services, limited to the following:

1. Genetic counseling provided to you by a physician, licensed or Master's trained genetic counselor or medical geneticist;

2. amniocentesis during pregnancy;

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

4. identification of infectious agents such as the influenza virus;

5. compatibility testing for a participant who has been approved by us for a covered transplant;

6. prenatal cystic fibrosis testing when ordered by an obstetrician in accordance with recommendations from the American College of Medical Genetics (ACMG) and American Congress of Obstetricians and Gynecologists (ACOG);

7. molecular testing of pathological specimens. Such testing does not include any testing of blood, except for (a) testing for the diagnosis of leukemia, lymphoma, or platelet abnormalities and (b) testing of the KRAS genetic variation for drug susceptibility; and

8. for the diagnosis or treatment of one of the illnesses listed below. Our prior approval is recommended for such genetic tests. If you do not receive our prior approval, benefits for such services may not be payable under the Plan and such services may not covered.

Benefits are payable if the disease being tested for is one of the following:

a. Canavan Disease;

b. Congenital Profound Deafness;

c. Cystic Fibrosis for participants who are not pregnant;

d. Factor V Leiden Thrombophilia;

e. Familial Adenomatous Polyposis Coli;

f. Gaucher Disease;

g. Hemoglobinopathies;

h. Hereditary Hemochromatosis;

i. Hereditary Non-Polyposis Colorectal Cancer;

j. Long QT Syndrome;

k. Mitochondrial Disorders;

l. Myotonic Dystrophy;

m. Niemann-Pick Disease;

n. Retinoblastoma;

o. Medullary Thyroid Cancer and Multiple Endocrine Neoplasia Type 2 RET testing;

p. Breast and Ovarian Cancer Susceptibility;

q. Tay-Sachs Disease; or

r. Von Hippel-Lindau Disease.

Since this list may change from time to time, you should contact us by calling the Customer Service telephone number shown on your WPS Identification Card, or log on to our internet website at www.wpsic.com, for the most current list of covered diagnoses for genetic testing.

Genetic testing for the following will not be covered: (a) testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone; (b) testing for conditions which can not be altered by treatment or prevented by specific interventions; (c) testing solely for the purpose of informing the care or management of a participant's family members; (d) testing for drug therapy, i.e. pharmacogenetics; and (e) genetic testing for any condition that does not appear on the above list or as updated on the WPS Internet website.

Health and Behavior Assessments

Health and behavior assessments and reassessments, diagnostic interviews and neuropsychological testing provided by a psychologist to treat a physical illness or injury.

Hearing Aids and Implantable Hearing Devices

Benefits are payable for charges for:

1. the cost of one hearing aid, per ear, per child every three years;

2. implantable hearing devices;

3. treatment related to hearing aids and implantable hearing devices, including procedures for the implantation of implantable hearing devices.

Paragraph 1. applies only to children under the age of 18 who are covered under the policy. Such hearing aids and implantable hearing devices must be prescribed by a physician or an audiologist in accordance with accepted professional medical or audiological standards.

The child must be certified as deaf or hearing impaired by a physician or audiologist.

Home Care Services

1. Covered Services.

This subsection applies only if charges for home care services are not covered elsewhere under the Plan. A Department-licensed or Medicare-certified home health agency or certified rehabilitation agency must provide or coordinate the services. You should make sure the agency meets this requirement before services are provided. Benefits are payable for charges for the following services:

a. Part-time or intermittent home nursing care by or under supervision of a registered nurse;

b. Part-time or intermittent home health aide services when 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;

c. Physical or occupational therapy or speech-language pathology or respiratory care;

d. Medical supplies, drugs and medications prescribed by a physician; 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 you had been hospitalized;

e. Nutrition counseling provided or supervised by a registered or certified dietician; and

f. Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. Your attending physician must request or approve this evaluation.

2. Limits on Home Care.

a. Home care isn't covered unless your physician certifies that: (1) hospitalization or confinement in a licensed skilled nursing facility would be needed if you didn't have home care; and (2) members of your immediate family, or others living with you, couldn't give you the care and treatment you need without undue hardship.

b. If you were hospitalized just before home care started, your physician during your hospital confinement must also approve the home care plan.

c. Benefits are payable for charges for up to the number of home care visits shown in the Schedule of Benefits per participant per calendar year. Each visit by a person to provide services under a home care plan, or for evaluating your need, or for developing a home care plan counts as one home care visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.

d. If home care is covered under two or more health insurance contracts, coverage is payable under only one of them, except as stated in section "COORDINATION OF BENEFITS".

e. The maximum weekly benefit payable for home care won't be more than the benefits payable for the total weekly charges for skilled nursing care available in a licensed skilled nursing facility, as determined by us.

Hospice Care

Benefits are payable for charges for covered expenses for hospice care services provided to a terminally ill participant if the participant's health condition would otherwise require his/her confinement in a hospital or a skilled nursing facility and hospice care is a cost effective alternative, as determined by us.

Hospice care services include services provided by a licensed public agency or private organization intended primarily to provide pain relief, symptom management, and medical support services to persons who are terminally ill. Hospice care services may be provided at hospice facilities or in the participant's place of residence.

Covered expenses for hospice care services shall include: (1) room and board at a hospice facility while the participant is receiving acute care to alleviate physical symptoms of his/her terminal illness; (2) physician and nursing care; (3) services provided to the participant at the participant's place of residence; and (4) five days of respite care. Room and board for residential care at a hospice facility is not covered.

Benefits are payable for charges for covered expenses for hospice care services provided to the participant during the initial six-month period immediately following the diagnosis of a terminal illness for that participant. Coverage for hospice care services to be provided to that participant after the initial six-month period will be extended by us under the Plan beyond the initial six month period, provided, a physician certifies in writing that the participant is terminally ill.

Hospital Services

We'll pay benefits for charges for the following hospital services. This subsection does not include services for stem cell, heart, heart/lung, liver, lung, pancreas or kidney transplants or treatment of alcoholism, drug abuse or nervous or mental disorders, except for inpatient hospital services for detoxification of drug addiction or alcohol dependency. Please see subsections "Nervous or Mental, Drug and Alcohol Treatment," "Kidney Disease Treatment" and "Transplants".

1. Inpatient hospital services for a physical illness or injury:

- **a.** Charges for room and board;
- **b.** Nursing services;
- **c.** Charges for miscellaneous hospital expenses;
- **d.** Charges for intensive care unit room and board;
- **e.** Charges for up to 120 hours or services provided by a private duty nurse or personal care assistant who has provided home care services to a ventilator-dependent participant, solely for the purpose of assuring adequate training of the hospital staff to communicate with that participant.

2. Miscellaneous hospital expenses for a physical illness or injury received by you while you are not confined in a hospital. These don't include charges for outpatient physical, speech, occupational or respiratory therapy.

3. Facility fees charged by the hospital for office visits and for urgent care visits.

The benefit levels that apply on the hospital admission date apply to the charges for covered expenses incurred for the entire confinement, regardless of changes in benefit levels during the confinement.

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

Infertility Services

Infertility diagnostic services directly provided to you. Benefits are payable only for infertility diagnostic services directly provided to you. Once there has been a diagnosis of infertility, there are no further benefits payable under the Plan. Benefits are not payable for any laparoscopic procedure during which an ovum is manipulated for the purpose of fertility treatment even if the laparoscopic procedure includes other purposes.

Kidney Disease Treatment

Benefits are payable for charges for the following health care services for treatment of kidney disease:

1. dialysis treatment, including any related medical supplies and laboratory services provided during dialysis and billed by the outpatient department of a hospital or by the dialysis center;

2. single kidney transplantation expenses of both recipient and donor.

This subsection only applies to single kidney transplants. Multiple organ transplants involving the kidney, for example, kidney/pancreas or kidney/liver, are payable under the organ transplant benefit in subsection "Transplants."

We won't pay benefits for any charges if you are eligible for, or covered by, Medicare. Please see exclusion 4. under section "GENERAL EXCLUSIONS" and section "COVERAGE WITH MEDICARE."

Mastectomy Treatment

A participant who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy and who elects breast reconstruction, will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Breast prostheses; and

4. Treatment of physical complications for all stages of mastectomy, including lymphedemas.

Maternity Services

Maternity services are: (1) prenatal and postnatal care; (2) laboratory procedures; (3) delivery of the natural newborn child; (4) cesarean sections; and (5) health care services for miscarriages.

An abortion procedure for the termination of a mother's pregnancy is covered only if: (1) the pregnancy is considered a life-threatening complication of the mother's existing physical illness; or (2) due to a lethal fetal anomaly; and (3) the abortion procedure is permitted by, and performed in accordance with, law. "Lethal fetal anomaly" is defined as an anomaly which predictably results in fetal demise either in utero or shortly (within 72 hours) after delivery.

Maternity services are payable when provided by a: (1) hospital; (2) physician; (3) certified nurse midwife.

With respect to confinements for pregnancy, the Plan shall not limit the length of stay to less than: (1) 48 hours for a normal birth; and (2) 96 hours for a cesarean delivery. However, you are free to leave the hospital earlier if the decision to shorten the stay is the mutual decision of the physician and mother.

Medical Services

Medical services for a physical illness or injury, including second opinions. Services must be provided: (1) in a hospital; (2) in a physician's office; (3) in an urgent care center; (4) in a surgical care center; (5) in a convenient care clinic; or (6) in your home. These services do not include home care services covered under subsection "Home Care Services".

Medical Supplies

Medical supplies prescribed by a physician. Medical supplies include, but are not limited to:

1. Strapping and crutches;

2. Ostomy bags and supplies, except charges such as those made by a pharmacy for purposes of a fitting are not covered;

3. Initial pair of eyeglasses or external contact lenses: (a) for aphakia; (b) for keratoconus; and (c) following cataract surgery; and

4. Elastic stockings or supports when prescribed by a physician and required in the treatment of an illness or injury. We may establish reasonable limits on the number of pairs allowed per participant per calendar year.

Nervous or Mental, Drug and Alcohol Treatment

1. **Definitions.**

The following definitions apply to this subsection only:

Collateral: a member of your immediate family.

Day Treatment Programs: nonresidential programs for alcohol and drug dependent participants and for treatment of nervous or mental disorders, which are operated by certified inpatient and outpatient Alcohol and Other Drug Abuse (AODA) facilities, that provide case management, counseling, medical care and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week; also known as partial hospitalization.

Hospital: (a) a hospital licensed under Section 50.35, Wisconsin Statutes, as amended; (b) an approved private treatment facility as defined in Section 51.45 (2) (b), Wisconsin Statutes, as amended; or (c) an approved public treatment facility as defined in Section 51.45 (2)(c), Wisconsin Statutes, as amended.

Inpatient Hospital Services: (a) services for the treatment of nervous or mental disorders, alcoholism or drug abuse that are directly provided to a participant who is a bed patient in the hospital; and (b) services for the treatment of alcoholism or drug abuse that are directly provided to a participant in a facility with a program certified by the Department under Section HFS 61.63, Wis. Adm. Code, as amended. However this definition shall not include those inpatient hospital services for detoxification of drug addiction or alcohol dependency. Please see subsection "Hospital Services."

Licensed Mental Health Professional: a clinical social worker who is licensed under ch. 457, a marriage and family therapist who is licensed under s. 457.10, or a professional counselor who is licensed under s. 457.12.

Outpatient Services: nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse problems directly provided to a participant and, if for the purpose of enhancing the participant's treatment, a collateral by any of the following: (a) a program in an outpatient treatment facility, if both the program and facility are approved by the Department and established and maintained according to rules promulgated under Section 51.42 (7)(b), Wisconsin Statutes, as amended; (b) a licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office; (c) a psychologist licensed or certified by the state in which he/she is located; (d) a licensed mental health professional practicing within the scope of his/her license; or (e) a health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse within the scope of that license.

Residential Treatment Programs: therapeutic programs for treatment of nervous or mental disorders and alcohol and drug dependent participants, including therapeutic communities and transitional facilities.

Transitional Treatment Arrangements: services for the treatment of nervous or mental disorders, alcoholism or drug abuse that are directly provided to you in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services, if both the program and the facility are approved by the Department as defined in the Section Ins 3.37, Wis. Adm. Code, as amended.

Transitional treatment services are services provided by a health care provider, and certified by the Department for each of the following (except h.) below:

a. mental health services for covered adults in a day treatment program;

b. mental health services for covered children and adolescents in a day treatment program;

c. services for participants with chronic mental illness provided through a community support program;

d. residential treatment programs for treatment of a participant's nervous or mental disorders and for alcohol and drug dependent participants or both;

e. services for alcoholism and other drug problems provided in a day treatment program;

f. intensive outpatient programs for narcotic treatment services for opiate addiction;

g. coordinated emergency mental health services for participants who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided; and

h. out-of-state services and programs that are substantially similar to (a), (b), (c), (d) and (e) if the provider is in compliance with similar requirements of the state in which the health care provider is located; and

The criteria that we use to evaluate a transitional treatment program or service to determine whether it is medically necessary and covered under the Plan include, but are not limited to, whether:

a. the program is certified by the Department;

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

c. the specific diagnosis is consistent with the symptoms;

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

e. the treatment plan is focused for the specific diagnosis;

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

We will need the following information from the health care provider to help us determine the medical necessity of such program or service:

a. a summary of the development of your illness and previous treatment;

b. a well-defined treatment plan listing treatment objections, goals and duration of the care provided under the transitional treatment arrangement program; and

c. a list of credentials for the staff who participated in the transitional treatment arrangement program or service, unless the program or service is certified by the Department.

2. Benefits.

Benefits are payable for charges for inpatient hospital services, outpatient services and transitional treatment arrangements.

No benefits are payable for charges for outpatient services provided to or received by a participant as a collateral of a patient which do not enhance the outpatient treatment of another participant who is also covered under the Plan.

Orthotic Devices and Appliances

Orthotic devices including fittings and adjustments of custom-made rigid or semi-rigid supportive devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. Covered orthotic devices include, but are not limited to:

1. Casts, splints and orthopedic braces;

2. Cervical collars;

3. Ankle orthosis;

4. Corsets (back and special surgical);

5. Wristlets;

6. Diabetic shoes when such diabetic shoes are medically necessary; and

7. Custom molded orthotic devices or appliances to support the foot, including orthotic devices that are a permanent part of an orthopedic leg brace.

Orthotic appliances may be replaced once per calendar year per participant when medically necessary. However, additional replacements will be allowed for participants under age 18 due to rapid growth, or for any participant when an appliance is damaged and can not be repaired.

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

Pain Management Treatment

Pain management treatment including injections and other procedures to manage a participant's pain related to an illness or injury.

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

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

2. radiofrequency neuroablation (neurolysis) of the facet joint nerves;

3. facet joint injections and medical branch nerve blocks;

4. trigger point injections;

5. epidural injections, other than epidural injections provided to the pregnant participant in connection with labor or delivery of a newborn child or due to surgery; and

6. sacroiliac joint injections;

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

If you do not receive our prior approval, benefits for such pain management injections and procedures may not be considered medically necessary and not covered under the Plan.

Prescription Legend Drugs

1. **Definitions.**

   The following definitions apply to this subsection only:

   Prescription Legend Drug: any medicine, including investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended, for which the Federal Food, Drug and Cosmetic Act, as amended, requires its label to contain the wording: "Caution: Federal Law prohibits dispensing without prescription" or similar wording. Prescription legend drugs shall include insulin.

   Specialty Drugs: prescription legend drugs that have some or all of the following characteristics, as determined by us: (a) produced through a biotechnology mechanism/process; (b) an association with complex clinical management; and (c) require close patient monitoring. Examples are those prescription drugs prescribed to treat illnesses including, but not limited to HIV/AIDS, rheumatoid arthritis, multiple sclerosis, hepatitis, psoriasis or cancer. A list of the most recent specialty drugs is shown in the General Information section of your WPS member guide. Since this list may change from time to time, you should visit our website at www.wpsic.com or contact us by calling the Customer Service telephone number shown on your WPS Identification Card to determine if the drug is a specialty drug that requires our prior approval.

2. **Prescription Legend Drugs including Specialty Drugs Provided in a Physician's Office, the Outpatient Department of a Hospital or by a Home Health Agency.**

   Our prior approval is required for specialty drugs provided in: (a) a physician's office; (b) the outpatient department of a hospital; or (c) by a home health agency. If you do not receive our approval prior to receiving a specialty drug, benefits may not be payable under the Plan. Specialty drugs purchased without our prior approval and submitted to us for reimbursement will be reviewed and are subject to our approval including applicable restrictions.

   If we determine that a prescription legend drug, including a specialty drug, is self-administerable and/or can be provided to you by a pharmacy, such drugs are not covered expenses and will not be covered under the Plan.

Preventive Care Services

Preventive care services include the following:

1. Immunizations. Benefits are payable for charges for immunizations including, but not limited to, the following: diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; and varicella. Immunizations for travel purposes are not covered.

2. Routine medical exams, including eye exams (including refraction), hearing exams, pelvic exams, pap smears, and any related routine diagnostic services, other than as specifically stated below. Pelvic exams and pap smears will be covered under this paragraph when directly provided to you by a physician, certified nurse midwife or a nurse practitioner. Please see the following paragraphs for coverage for well baby care and routine mammograms. This paragraph does not apply to health care services to treat an illness or injury.

3. Routine medical exams, including eye exams (including refraction), hearing exams, and any related routine diagnostic services directly provided to a dependent child who is a participant. This paragraph includes those routine services directly provided by a physician to a newborn child who is a participant during the child's inpatient confinement following his/her birth (for example, circumcision). This paragraph does not apply to health care services to treat an illness or injury.

4. Routine examination by low-dose mammography of a female participant per calendar year. Mammograms must be performed by or under the direction of a physician, certified nurse midwife or licensed nurse practitioner.

5. Blood lead tests for participants age five and under.

6. Colorectal cancer screening in accordance with the most current guidelines of the United States Preventive Services Task Force, including fecal occult blood testing, one routine sigmoidoscopy or colonoscopy every five years. Any additional routine sigmoidoscopies or colonoscopies performed within that five year period shall be payable subject to applicable deductible and coinsurance provisions.

Prosthetics

Prosthetic devices and supplies, including the fitting of such devices, which replace all or part of: (1) an absent body part (including contiguous tissue); or (2) the function of a permanently inoperative or malfunctioning body part. Such prosthetics include a full cranial hair prosthetic (wig) in the case of hair loss due to cancer treatment limited to one wig per participant per calendar year. The Plan does not cover dental prosthetics.

Our prior approval is required on any prosthetic with a total purchase price greater than $3,000. If you do not receive our prior approval in accordance with subsection "Prior Approval of Health Care Services", benefits will be reduced by 20% of the charges for covered expenses for such a prosthetic.

Radiation Therapy and Chemotherapy Services

Radiation therapy and chemotherapy services for therapeutic treatment of covered benign or malignant conditions, including charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in treatment.

Skilled Nursing Care in a Licensed Skilled Nursing Facility

Benefits are payable for covered expenses incurred by you for charges made by a licensed skilled nursing facility for room and board and other health care services. Your confinement to a licensed skilled nursing facility must be based upon a written recommendation of a physician. Benefits are payable for up to the number of days shown in the Schedule of Benefits per confinement for that participant. The day limit stated in this paragraph will be reduced by any charges for such days of confinement that are applied to the applicable deductible amounts.

Benefits are only payable for skilled nursing care which is certified as medically necessary by your attending physician and is recertified as medically necessary every seven days and is not essentially domiciliary or custodial care.

No benefits are payable for domiciliary care, maintenance care, supportive care, custodial care, or for care which is available at no cost to you or provided under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes, as amended).

Surgical Services

Benefits are payable for charges for the following surgical services. This subsection does not include surgical services for stem cell, heart, heart/lung, liver, lung, pancreas or kidney transplants or treatment of alcoholism, drug abuse or nervous or mental disorders. Please see subsections "Nervous or Mental, Drug and Alcohol Treatment", "Kidney Disease Treatment" and "Transplants".

Covered surgical services include, but are not limited to:

1. operative and cutting procedures;

2. endoscopic examinations, such as arthroscopy, bronchoscopy, non-routine colonoscopy, laparoscopy;

3. other invasive procedures such as angiogram, ateriogram, tap or puncture of brain or spine; and

4. non-routine sigmoidoscopy.

The following surgical services are covered when provided in a physician's office, hospital, or licensed surgical center:

1. Surgical services, other than oral surgical services.

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

2. Oral surgical services, including related consultation, x-rays and anesthesia.

3. Orthognathic surgery for the treatment of severe dysmorphia where a functional occlusion can not be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include, but are not limited to, significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre or post operatively, including surgical rapid palatal expansion) are not covered under this paragraph.

4. Corneal, allogenic tendons and ligament transplants.

5. Bone and skin grafts.

Temporomandibular Joint Disorders (TMJ)

Diagnostic procedures and medically necessary surgical and non-surgical treatment for the correction of temporomandibular disorders if all of the following apply:

1. the condition is caused by congenital, developmental or acquired deformity, disease or injury;

2. under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition; and

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

Benefits are not payable for cosmetic or elective orthodontic care, periodontic care or general dental care.

Therapy Services

Benefits for therapy services are limited to the following:

1. Outpatient physical, speech, occupational, massage and respiratory therapy. The therapy must be expected to significantly improve your physical health within 60 days of the date on which such therapy begins. The therapy must be performed by a physician, licensed physical, speech, occupational or respiratory therapist, or any other health care provider approved by us. The licensed physical, speech, occupational or respiratory therapist or other health care provider must be providing the therapy under the direction of your physician. If a license to perform such therapy is required by law, that therapist or other health care provider must be licensed by the state in which he/she is located and must provide such therapy while he/she is acting within the lawful scope of his/her license. Physical therapy for your temporomandibular joint disorder is not covered under this paragraph. The visit limit stated in this paragraph will be reduced by any charges for such visits that are applied to the applicable deductible amounts.

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

3. Enteral therapy (tube feeding) including enteral forumlas and related supplies for use at home by a participant if prescribed by a physician and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

Transplants

1. Definitions.

The following definitions apply to this subsection only:

Autologous: the source of cells is from the participant's own marrow or stem cells.

Allogenic: the source of cells is from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant: when the bone marrow is harvested from the participant and stored. The participant undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then reinfused (transplanted).

Allogenic Bone Marrow Transplant: when the bone marrow is harvested from a donor and stored. The participant undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then reinfused (transplanted).

Autologous/Allogenic Stem Cell Transplant: a treatment process that includes stem cell harvest from either bone marrow or peripheral blood or cord blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and related care. Autologous/allogenic bone marrow transplantations and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogenic stem cell support.

Recipient: a participant who receives a human to human organ or tissue transplant that's a covered transplant procedure.

Transplant Preferred Provider: (1) the hospital and/or physicians listed in the most recent Directory of Transplant Preferred Providers; or (2) a preferred provider when transplant services are provided while the recipient is not confined in a hospital; or (3) any other health care provider approved by us. The directory is available on the Internet at www.urnweb.com. Please note that transplant preferred providers may change periodically. While the on-line directory is updated frequently, the presence of a provider's name in the listing does not guarantee or mean that that specific provider participates in that network at the same time that a participant receives any service from that provider.

Transplant Services: transplantation (including retransplants) of the human organs or tissue listed below, including all related post-surgical treatment, excluding drugs, and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of FDA approved Ventricular Assist Devices (VAD), functioning as a temporary bridge to heart transplantation.

2. Benefits.

Benefits are payable only for charges for eligible transplant services (as defined above) while you are covered under the Plan. Transplants that will be considered for coverage are limited to the following:

a. Kidney transplants for end-stage disease.

b. Cornea transplants for end-stage disease.

c. Heart transplants for end-state disease.

d. Lung transplants or heart/lung transplants for: (1) primary pulmonary hypertension; (2) Eisenmenger's syndrome; (3) end-stage pulmonary fibrosis; (4) alpha 1 antitrypsin disease; (5) cystic fibrosis; and (6) emphysema.

e. Liver transplants for: (1) biliary atresia in children; (2) primary biliary cirrhosis; (3) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (4) primary sclerosing cholangitis; (5) alcoholic cirrhosis; and (6) hepatocellular carcinoma.

f. Allogenic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (1) acute myelogenous leukemia; (2) acute lymphocytic leukemia; (3) chronic myeloenous leukemia; (4) severe combined immunodeficiency disease; (5) Wiskott-Aldrich syndrome; (6) aplastic anemia; (7) sickle cell anemia; (8) non-relapsed or relapsed non-Hodgkin's lymphoma; (9) multiple myeloma; and (10) testicular cancer.

g. Autologous bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (1) acute leukemias; (2) non-Hodgkin's lymphoma; (3) Hodgkin's disease; (4) Burkitt's lymphoma; (5) neuroblastoma; (6) multiple myeloma; (7) chronic myelogenous leukemia; and (8) non-relapsed non-Hodgkin's lymphoma.

h. Pancreas tranplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone.

The transplant-related treatment provided, including the expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums and other provisions of the Plan.

Medical and hospital expenses of the donor are covered only when the recipient is a participant and the transplant and directly related donor expenses have been prior authorized for coverage. Treatment of medical complications that may occur to the donor are not covered. Donors are not considered participants, and are therefore not eligible for the rights afforded to participants under the Plan.

GENERAL EXCLUSIONS

The following aren't covered under the Plan. The Plan provides no benefits for:

1. Health care services and supplies, or equipment for any illness or injury: which occurs in the course of employment; for which you are eligible for compensation, in whole or in part, under any Worker's Compensation Act or Employer Liability Law. This exclusion applies whether or not you claim the benefits or compensation or recover losses from a third party.

2. Health care services furnished by the U.S. Veterans Administration, except for such health care services for which under applicable federal law the Plan is the primary payer and the U.S. Veterans Administration is the secondary payer.

3. Health care services furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless such coverage under the Plan is required by any state or federal law.

4. Health care services covered by Medicare, if you have or are eligible for Medicare, to the extent benefits are or would be available from Medicare, except for such health care services for which under applicable federal law the Plan is the primary payer and Medicare is the secondary payer. Please also see section "COVERAGE WITH MEDICARE".

5. Health care services for any injury or illness caused by: (a) atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile.

6. Cosmetic treatment, except for health care services related to port wine stain removal.

7. Reconstructive surgery, except for such surgery required: (a) to repair a significant defect caused by an injury; (b) to repair a defect caused by congenital anomaly causing a functional impairment of a dependent child; (c) incidental to a mastectomy; or (d) due to a physical illness.

8. Health care services which aren't medically necessary for the treatment of an illness or injury, as determined by us.

9. Health care services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies. However, if a court orders an examination for a child, the initial examination will be covered. Court ordered treatment for behavioral health services will be covered as determined by us.

10. Preparation, fitting, or purchase of eyeglasses or contact lenses, except as specifically stated in the Plan; vision therapy, including orthoptic therapy and pleoptic therapy; or eye refractive surgery.

11. Health care services provided at any nursing facility or convalescent home or expense in any place that's primarily for rest, for the aged or for drug abuse or alcoholism treatment, except as specifically stated in subsection "Nervous or Mental, Drug and Alcohol Treatment".

12. Custodial care; rest care; respite services, except as specifically stated in the Plan.

13. Health care services which are experimental or investigative, except for the investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended.

14. Medical supplies and durable medical equipment for your comfort, personal hygiene or convenience, including, but not limited to: 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.

15. Health care services for, or leading to, sex transformation surgery, the sex transformation surgery, and sex hormones related to such surgery.

16. Reversal of sterilization.

17. Therapy services such as recreational therapy (other than recreational therapy included as part of a treatment program received during an inpatient hospital confinement for treatment of nervous or mental disorders, alcoholism or drug abuse), educational therapy, physical fitness, or exercise programs, except as specifically stated in subsection "Cardiac Rehabilitation Services" and "Therapy Services".

18. Artificial insemination or fertilization methods, including, but not limited to, in vivo and 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. In addition, infertility diagnostic services or infertility evaluation and management services, and related services that are provided after the commencement of the participant's infertility treatment are not covered under the Plan.

19. Follicle-stimulating hormone (FSH), activity medications, or ovulatory stimulant medications, including, but not limited to, Menotropins, Chorionic Gonadotropins, Urofollitropins and Clomiphene Citrate.

20. Health care services not specifically identified as being covered under the Plan.

21. Dental treatment, services, procedures, drugs, medicines, devices and supplies, except as specifically stated in subsection "Dental Services".

22. Health care services not provided by a physician or any of the health care providers listed in section "COVERED EXPENSES".

23. Health care services provided: (a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet which are billed as routine and not associated with a medical diagnosis; (b) in the cutting or trimming of toenails which are billed as routine or associated with a medical diagnosis, except for the medical diagnosis of diabetes; or (c) in the non-operative partial removal of toenails which are billed as routine or not associated with a medical diagnosis.

24. Abortion procedures for the termination of pregnancy, except as specifically stated in subsection "Maternity Services".

25. Health care services provided when your coverage was not effective under the Plan. This includes health care services provided either prior to your effective date of coverage or after your coverage terminated under the Plan. Please see section "TERMINATION OF COVERAGE".

26. Health education; marriage counseling; complimentary, alternative or holistic medicine; or other programs with an objective to provide complete personal fulfillment.

27. Health care services for, or used in connection with, transplants of human and non-human body parts, tissues or substances, implants of artificial or natural organs or any complications of such transplants or implants, except as specifically stated in subsection "Transplants".

28. Health care services provided to or received by a participant as a collateral in connection with treatment of any person who is not a participant under the Plan.

29. Housekeeping, shopping, or meal preparation services.

30. Vitamins, dietary supplements, and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g. phenylketonuria (PKU)), unless specifically stated otherwise in the Plan.

31. Health care services for obesity, weight reduction, dietetic control or morbid obesity; obesity surgery for GERD.

32. Retin-A, Minoxidil, Rogaine, or their medical equivalent in the topical application form, unless medically necessary.

33. Health care services used in educational or vocational training or testing.

34. Health care services provided in connection with: (a) any illness or injury caused by your engaging in an illegal occupation; or (b) any illness or injury caused by your commission of, or an attempt to commit, a felony.

35. Maintenance care or supportive care.

36. Health care services provided in connection with the temporomandibular joint or TMJ syndrome, except as specifically stated in subsection "Temporomandibular Joint Disorder".

37. Oral surgical services, except as specifically stated in subsection "Surgical Services" and subsection "Temporomandibular Joint Disorder".

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

39. Health care services provided in connection with a health care service not covered under the Plan. An example would be inpatient hospital services in connection with a health care service not covered under the Plan.

40. That portion of the amount billed for a health care service covered under the Plan that exceeds our determination of the charge for such health care service.

41. Health care services for which you have no obligation to pay.

42. Contraceptive devices and medications, except as specifically stated in subsections "Contraceptives for Birth Control" and "Prescription Legend Drugs."

43. Health care services for which proof of claim isn't provided to us in accordance with subsection "Proof of Claim".

44. Foot orthotics, special shoes or devices, unless they are a permanent part of an orthopedic leg brace, unless specifically stated otherwise in the Plan.

45. Health care services not for or related to an illness or injury, other than as specifically stated in the Plan.

46. Wigs, prosthetic hair pieces, hair transplants, or hair implants, except as specifically stated in the Plan.

47. Sales tax or any other tax, levy, or assessment by any federal or state agency or a local political subdivision.

48. Indirect services provided by health care providers for services such as, but are not limited to: creation of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; and reviewing quality assurance data; transport of lab specimens; physician concierge payments; after hours charges.

49. Dental repair of your sound natural teeth due to an accident caused by chewing resulting in damage to your sound natural teeth.

50. Treatment of weak, strained, flat, unstable or unbalanced feet; arch supports; heel wedges; lifts; orthopedic shoes; or the fitting of orthotics to aid walking or running, except as specifically stated in the Plan.

51. Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs and all related material and products for these programs.

52. Medications, drugs, or hormones to stimulate human biological growth, unless there is a laboratory-confirmed physician's diagnosis of the participant's growth hormone deficiency.

53. Massage therapy, except as specifically stated in subsection "Therapy Services."

54. Therapy and testing for treatment of allergies, including, but not limited to services related to clinical ecology, environmental allergy, allergic immune system dysregulation, sublingual antigen(s), RAST test, extracts, neutralization tests and/or treatment unless such therapy or testing is approved by The American Academy of Allergy, Asthma and Immunology (AAAAI).

55. Genetic testing of a participant, except as specifically stated in subsection "Genetic Services".

56. Completion of claim forms or forms necessary for a participants return to work or school or for an appointment a participant did not attend.

57. Smoking deterrents, such as, but not limited to, prescription legend drugs, patches, gum, hypnosis, except as specifically stated in subsection "Prescription Legend Drugs."

58. Health care services not supported by information contained in your medical records or from other relevant sources.

59. Durable medical equipment or prosthetics that have special features.

60. Health care services provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in the custody of law-enforcement officials, except as specifically stated in s. 609.65, Wisconsin Statutes. Persons on work release are not considered to be held, detained or imprisoned if they are otherwise eligible participants.

61. Preparation, fitting or purchase of hearing aids and other internal or external hearing devices, including related services, except as specifically stated in subsection "Hearing Aids and Cochlear Implants."

62. Nutritional counseling, except for treatment of diabetes.

63. Health care services provided for your convenience or for the convenience of a physician, hospital, or other health care provider.

64. Private duty nursing service, except as specifically stated in the Plan.

65. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a health care provider.

66. Health club memberships.

67. Prescription legend drugs, except as specifically stated in the Plan.

COORDINATION OF BENEFITS

Applicability

1. This section applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. "Plan" and "this plan" are defined below.

2. If this section 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 subsection "Effect on the Benefits of This Plan."

Definitions

Allowable Expense: 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 semiprivate 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 in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided shall be considered both an allowable expense and a benefit paid.

Claim Determination Period: 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: any of the following which provides benefits or services for, or because of, medical 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 Medicare and Medicaid. 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.

3. Medical expense benefits coverage in group, group-type, and individual automobile "no-fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis are included.

Each contract or other arrangement for coverage under 1., 2. or 3. is a separate plan. 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 states whether this plan is a primary plan or secondary plan as to another plan covering the person.

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 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 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: the part of the Plan that provides benefits for health care expenses.

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 which has its benefits determined after those of the other plan, unless:

- **a.** the other plan is automobile medical expense benefit coverage and has rules coordinating its benefits with those of this plan; and
- **b.** both those rules and this plan's rules, described in paragraph 2. below, 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, participant or subscriber are determined before those of the plan which covers the person as a dependent of an employee, participant or subscriber.
- **b.** **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph 2. c., when this plan and another plan cover the same child as a dependent of different persons, called "parents":
  - **(1)** 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
  - **(2)** 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 rules described in (1) 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:
  - **(1)** first, the plan of the parent with custody of the child;
  - **(2)** then, the plan of the spouse of the parent with custody of the child; and
  - **(3)** 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 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 subparagraph 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 rule d. is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this subparagraph d.

e. **Continuation Coverage.**

(1) 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: (a) first, the benefits of a plan covering the person as an employee, participant or subscriber or as a dependent of an employee, participant or subscriber; (b) second, the benefits under the continuation coverage.

(2) If the other plan does not have the rule described in (1) above, and if, as a result, the plans do not agree on the order of benefits, this subparagraph 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, participant or subscriber longer are determined before those of the plan which covered that person for the shorter time.

Effect on the Benefits of This Plan

1. **When This Paragraph Applies.** This paragraph applies when, in accordance with subsection "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 paragraph 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 section; 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 section, whether or not claim is made. Under this provision, 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.

Right to Receive and Release Needed Information

The Claim Administrator has the right to decide which 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 participant but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under this plan must give

the Claim Administrator any facts it needs to pay benefits under the Plan.

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 Claim Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. The Claim Administrator 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.

Right of Recovery

If the amount of the payments made by the Claim Administrator under the 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 the payments made" includes the reasonable cash value of any benefits provided in the form of services.

TERMINATION OF INDIVIDUAL COVERAGE

All Participants

A participant's coverage under the Plan shall end on the earliest of the following dates:

1. The date the Plan terminates;

2. The day immediately following the last day of the calendar month the participant dies;

3. The day immediately following the last day for which a participant's contribution, if any, has been paid;

4. The date the participant enters into military service, other than for duty of less than 30 days;

5. For a covered employee:

- **a.** the day immediately following the last day of the calendar month we determine he/she failed to return to work from a leave of absence protected by the Wisconsin Family and Medical Leave Act (WFMLA), the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA); or
- **b.** the day immediately following the last day of the calendar month he/she has not been actively at work for at least 30 consecutive calendar days for a period of absence not protected by WFMLA, FMLA or USERRA; or
- **c.** the day immediately following the last day of the calendar month he/she ceases to be an eligible employee, as determined by the Employer.

The Employer must notify us immediately if the covered employee ceases to be actively at work and no longer eligible for coverage under the Plan.

6. For a covered employee's dependent who is a participant, the date the covered employee's coverage terminates.

Spouse

Coverage under the Plan shall end on the earliest of the dates in subsection "All Participants." Coverage shall also end on the date the spouse is no longer married to the employee due to divorce or annulment.

Dependent Child

Coverage under the Plan shall end on the earliest of the dates in subsection "All Participants" and the following dates, as determined by the Claim Administrator:

1. The date the child marries, unless the child is under age 26;

2. The day immediately following the last day of the calendar year in which the married child reaches age 26

3. The day immediately following the last day of the calendar year in which the child reaches age 27, provided he/she is not a full-time student as defined in the Plan;

4. The day immediately following the last day of the calendar month in which the Claim Administrator determines that the dependent child is eligible under his/her employer's health plan as an employee for which the amount of the child's premium contribution is not greater than the premium amount of his/her coverage under the Plan;

5. For a child of a dependent child who is a participant, the date the dependent child reaches age 18.

A full-time student who attains the limiting age while covered under the Plan will remain eligible for benefits until the day immediately following the last day of the calendar month in which the child ceases to be a full-time student as defined in the Plan.

If a dependent has attained the limiting age while covered under the Plan and continues coverage as a full-time student, he/she may continue coverage if he/she ceases to be a full-time student due to a medically necessary leave of absence. In order to continue coverage, we must receive written documentation and certification of the medical necessity of the leave of absence from his/her attending physician. The date on which he/she ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which coverage continuation begins.

Coverage shall continue for that full-time student until the earliest of the following dates:

1. The date he/she marries;

2. The date he/she is eligible for coverage under a group health benefit plan as an employee; or the date he/she is eligible under a group health benefit plan as an employee for which the amount of his/her premium contribution is less than the premium amount for his/her coverage as a dependent under the Plan;

3. The date coverage of the insured through whom he/she has dependent coverage under the Plan is discontinued or not renewed; or

4. One year following the date his/her continuation coverage began and he/she has not returned to school on a full-time basis.

If you have family coverage under the Plan, a dependent child who is a mentally retarded or physically handicapped may continue coverage under your family coverage beyond the limiting age as set forth in subsection "Eligible Dependent".

It is the covered employee's responsibility to notify the Claim Administrator of his/her child losing dependent status. If he/she does not so notify the Claim Administrator, the covered employee shall be responsible for any claim payments made during the period of time the dependent was not eligible for coverage under the Plan.

Covered Retiree

For a covered retiree, the earliest of the following dates:

1. The date the covered retiree requests the termination of his/her coverage under the Plan.

2. The day immediately following the last day of the calendar month for which the premium required for his/her coverage has been paid in accordance with the Plan;

3. The day immediately following the last day of the calendar month the eligible retiree dies.

If the retiree dies, the spouse may continue coverage under the Plan for himself/herself and any covered dependents until the spouse elects to terminate his/her coverage or the spouse's coverage is terminated for nonpayment of premium. Covered dependents' coverage shall end as stated above or when the spouse's coverage terminates, whichever is earlier.

CONTINUATION COVERAGE

The covered employee or a family member has the responsibility to inform the Employer within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan in order to be eligible for COBRA continuation.

All participants covered under the Plan who would otherwise lose coverage as the result of a "qualifying event" have the right to elect continued health care coverage.

A qualifying event is any one of the following events which, but for continuation of coverage, would result in the loss of health insurance coverage:

1. the death of the covered employee;

2. the termination of the covered employee (other than by the employee's gross misconduct);

3. a reduction in a covered employee's hours of employment;

4. the divorce or annulment of the covered employee from the employee's spouse;

5. the covered employee's becoming entitled to Medicare coverage; or

6. the cessation of dependent child coverage under the terms of the Plan (for example, upon the employee's child attaining the limiting age of the Plan).

No employee, spouse or child will be considered a participant unless, on the date before the qualifying event, that individual was covered under the Plan.

Within 14 days of the Employer receiving notice to end coverage, the Employer must notify the participant of:

1. His/her option to continue or convert his/her coverage;

2. The amount the participant must pay monthly to continue his/her coverage under the Plan. The amount for continued coverage under the Plan will be the rate required for others in the Plan;

3. The manner in which and the place to which the participant must make premium payment; and

4. The time by which the participant must pay for continued coverage.

A participant must elect continuation coverage during the 60 day period (1) beginning on the date coverage would otherwise terminate due to a qualifying event or (2) beginning on the date the participant receives notice of his/her continuation rights.

If the participant elects to continue coverage within the 60 day period, the continuation coverage must be effective as of the date of the qualifying event. A participant who elects coverage will be charged with the cost of the coverage during the 60 day period.

The initial coverage premium must be received within 45 days of enrolling. Thereafter, premium payments are due in advance and payable no later than the last day of each month.

If a participant fails to apply for coverage within the 60 day period described above, or he/she fails to send his/her first premium payment within 45 days of enrolling, he/she will forfeit his/her right to coverage under the Plan.

If a covered employee who elects continuation coverage wishes to change to family coverage to add his/her newborn natural child or adopted child, he/she must apply within 30 days of the birth, adoption or placement for adoption. The effective date for such family coverage will be the date of that child's birth, adoption or placement for adoption.

The duration of continuation coverage which begins on the date of the qualifying event is as follows:

1. For spouses of deceased employees, divorced spouses, spouses of Medicare eligible employees and dependent children who would otherwise become ineligible for coverage under the Plan, continuation coverage will be provided for 36 months.

2. For terminated employees and employees with reduced hours, continuation coverage will be provided for 18 months. If an employee or his/her spouse or dependent children who are covered under the Plan are disabled as defined by Social Security at the time of termination of employment or the reduction in hours which triggered the qualifying event or during the first 60 days of continuation coverage, coverage will be provided for an additional extension of 11 months at an increased premium, but only if the employee, spouse or dependent notifies the Employer within 60 days of the date of the Social Security disability determination.

However, if one of the following events occurs before the expiration of the 18 or 36 months period, coverage will end at that time:

1. the termination of the Plan;

2. the failure to make timely premium payments under the Plan;

3. the participant becomes covered under another group health plan as a result of employment, reemployment, or remarriage;

4. the participant becomes entitled to Medicare benefits; or

5. the participant becomes covered under another group health plan provided the new plan does not contain any exclusion or limitation with respect to any pre-existing condition of the participant.

COVERAGE WITH MEDICARE

Carve-Out

If covered charges are incurred by a participant who is eligible to apply for Medicare, the Claim Administrator will determine the benefits, if any, payable for those charges for health care services covered under the Plan using its Medicare "Carve-Out" method. A participant who is eligible for Medicare is considered enrolled in and covered under Medicare Parts A and B, whether or not he/she is actually enrolled in one or both parts of Medicare. For example, if a participant is eligible to enroll in Medicare Part B, but fails to do so, or terminates his/her Medicare Part B coverage, the Claim Administrator will still determine the benefits payable under the Plan as if that participant had Medicare Part B coverage and Medicare paid Part B benefits, even if Medicare didn't pay any Part B benefits.

When using this method, benefits will be determined by the Claim Administrator as follows:

1. covered charges are determined; and

2. the amount of benefits Medicare paid or would have paid for these same charges is subtracted from the amount determined in a. above; and

3. the remaining balance, if any, is the amount the Claim Administrator will use in computing the benefits payable under the Plan. The deductible, coinsurance, if any, and all the terms, conditions and provisions of the Plan will be applied to determine the benefits, if any, payable on the balance.

This Medicare "Carve-Out" method of computing benefits for participants eligible for Medicare shall apply unless the Employer submits proof in a form satisfactory to the Claim Administrator that federal law requires greater benefits be paid under the Plan. In such event, the Plan shall pay the additional benefits required by that law.

Medicare as Secondary Payer.

If covered charges are incurred by a participant who is a Medicare beneficiary, the Claim Administrator will determine the benefits payable under the Plan using the following rules. The rules require Medicare to pay as secondary (and the employer group health plan as primary) when:

1. The covered participant (employee or the employee's spouse) is age 65 or older and is covered under an employer group health plan of an employer that employs at least 20 persons (including part time employees) for a minimum of 20 weeks during the current or preceding calendar year and has not elected to have Medicare as the sole source of medical protection.

2. The covered participant is under age 65, is covered under an employer group health plan of an employer of at least 100 employees, as a result of the participant's current employment status or that of a covered family member, and is receiving Medicare benefits due to a permanent and total disability. In this case, the employer must have at least 100 people actively employed 50 percent or more of the regular business days in the preceding calendar year.

   A person with "current employment status" is an individual who is working as an employee, is the employer (including self-employed persons) or is an individual associated with the employer in a business relationship.

3. A participant is covered under an employer group health plan, and has end-stage renal disease (ESRD). If an ESRD patient has health insurance coverage under an employer group health plan, Medicare is secondary for 30 months from entitlement to, or eligibility for, Medicare Part A based on ESRD.

OTHER FEDERAL PROVISIONS

Family and Medical Leave Act

If an employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, a covered employee's employer will continue coverage under the Plan in accordance with the employer's Human Resource policy on family and medical leaves of absence, as if the employee was actively at work if the following conditions are met:

1. Contribution is paid; and
2. The employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

1. The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or
2. The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the employee becomes actively at work:

1. No new waiting period will apply; and
2. Pre-Existing conditions exclusion shall not apply.

Qualified Medical Child Support Orders Provision

A dependent child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

1. The name and last known mailing address of the participant;
2. The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
3. A reasonable description of the type of coverage to be provided to the child or the manner in which such coverage is to be determined; and
4. The period to which the order applies.

Please contact the Plan Administrator if you would like a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers offering group health coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of the above periods. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Also under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

Summary of Material Reductions Rule

HIPAA requires group health plans to furnish each participant with a summary of any material reductions in covered benefits no later than 60 days after the adoption of the change.

Additional Provisions

This group health plan also complies with the provisions of the:

1. Mental Health Parity Act.

2. Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.

3. Pediatric Vaccines regulation, whereby employers will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.

4. Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA).

5. Medicare Secondary Payer regulations, as amended.

6. Uniformed Services Employment and Re-employment Rights Act (USERRA).

ADDITIONAL PROVISIONS

Proof of Claim

A participant, or the physician, hospital or other health care provider on the participant's behalf, must submit written proof of his/her claim for each treatment, service or supply provided to him/her to the Claim Administrator within 120 days of the date on which he/she receives that treatment, service or supply. Written proof of his/her claim includes: (1) the completed claim forms if required by the Claim Administrator; (2) the actual itemized bill for each treatment, service or supply; and (3) all other information that the Claim Administrator needs to determine the Employer's liability to pay benefits under the Plan, including, but not limited to, medical records and reports. Circumstances beyond a participant's control might prevent him/her from submitted such proof to the Claim Administrator within this time period. If so, he/she must file written proof of his/her claim with the Claim Administrator as soon as possible; but it can't be later than one year and 120 days after such treatment, service or supply was provided to him/her, unless the participant is legally incapacitated as determined by a court of law during this entire period. If the Claim Administrator doesn't receive the written proof of claim required by the Claim Administrator within that one-year and 120-day period and the participant is not legally incapacitated, no benefits are payable for that treatment, service or supply under the Plan.

Physician, Hospital or Other Health Care Provider Reports

Physicians, hospitals and other health care providers must give the Claim Administrator their records and reports to help the Claim Administrator determine benefits due to a participant. By accepting coverage under the Plan the covered employee agrees to authorize his/her physicians, hospitals and other health care providers to release all medical records and reports to the Claim Administrator for himself/herself and all his/her dependents. This is a condition of the Plan providing coverage to the covered employee and all his/her dependents. It's also a continuing condition of the Plan paying benefits. The covered employee expressly authorizes and directs the following to release these records and reports to the Claim Administrator: (1) any physician who has diagnosed for, attended, treated, advised or provided professional services to a participant; (2) any hospital in which that participant was treated or diagnosed; and (3) any other health care provider who has diagnosed for, attended, treated, advised or provided treatment, services or supplies to a participant. The covered employee authorizes them to furnish to the Claim Administrator any and all information related to the treatment, services, supplies or facilities provided to or used by a participant, to the extent required by a particular situation and allowed by applicable law. The covered employee also expressly authorizes the Claim Administrator to release to or obtain from any other insurance company or service or benefit plan the information which the Claim Administrator needs to determine the Employer's liability to pay benefits under the Plan.

Assignment of Benefits

This coverage is just for the covered employee and his/her dependents. Benefits may be assigned to the extent allowed by applicable laws and regulations.

Subrogation

1. Right to First Reimbursement and First Recovery.

When the Plan advances benefits to, or on behalf of, any participant because of a disability or loss which may have been caused by another person, corporation, or any other entity, or which is covered by any other insurance Plan, benefit plan, fund or self-funded plan, the Plan shall have the following rights to recover 100% of the benefits advanced to, or on the behalf of, the participant, in addition to any other rights available to the Plan under applicable law:

a. A right of first reimbursement from, and an automatic first lien upon, any judgment, settlement or other amount payable to, or on behalf of, the participant or the participant's estate on account of the disability or loss, regardless of the source of the funds or the sufficiency or the allocation of the amount payable and with first priority over any other payouts demanded or claims asserted by any other party. The proceeds of any judgment, settlement or other amount subject to this provision shall be held in trust for the benefit of the Plan; and

b. A right of first recovery from and against any insurance company, corporation, or other entity which has insured or covers the participant against damages, costs, or expenses arising from the disability or loss sustained by the participant, including, but not limited to, uninsured motorist insurance coverage, underinsured motorist coverage, "no-fault" insurance coverage, any applicable umbrella insurance coverage, or medical payments coverage under any type of insurance coverage; and

c. A right of first recovery from and against any person, corporation or other entity who or which is or may be liable or responsible for the disability or loss.

2. Assignment of Claims and Pursuit of Recovery and Reimbursement.

By accepting coverage under the Plan, each participant hereby assigns irrevocably and forever to the Plan all of that participant's rights, claims and causes of action as outlined above to the extent of all benefits advanced. In turn, the Plan hereby assigns all of its rights of recovery and reimbursement, including, but not limited to, the assigned rights, claims, and causes of action of the participant to the Claim Administrator.

No settlement, compromise or waiver of any rights, claims, or causes of action by any participant or his/her attorney, agent or representative shall be entered into without that person first obtaining the Claim Administrator's written consent. The participant agrees not to do anything that prejudices, hinders, adversely affects, or changes any of the Plan's and Claim Administrator's rights under this provision. Entering into any such settlement, compromise, or waiver by the participant or his/her attorney, agent, or representative is a breach of the Plan; such breach shall be deemed to prejudice the Plan's and Claim Administrator's rights under this provision.

The Claim Administrator has the option to take all reasonable action to protect its rights, including, but not limited to, bringing a lawsuit or other legal action in the participant's name, the Plan's name or its name against any person, corporation or other entity who or which is or may be liable or responsible for the disability or loss. The Plan or Claim Administrator is entitled to recover its attorneys' fees, court costs and any other costs or expenses of recovery or collection which may be incurred by the Plan or Claim Administrator in obtaining or securing the recovery or reimbursement from any proceeds received by, or under the control of, the participant or their attorney, agent, or representative.

Neither the Plan nor the Claim Administrator shall be liable or responsible for nor shall their recovery or reimbursement be reduced or diminished under any circumstances by attorneys' fees, court costs, or any other costs or expenses of recovery or collection which may be incurred by the participant, or any other person, corporation, or other entity representing the participant or acting on their behalf.

The participant shall promptly advise the Plan and Claim Administrator in writing whenever a right, claim, or cause of action is asserted or made against any person, corporation, or other entity by, or on behalf of, that participant. The participant or his/her attorney, agent, or representative shall provide the Plan and Claim Administrator with any

information requested by the Plan or Claim Administrator. The participant shall execute any documents and do whatever else the Plan or Claim Administrator shall reasonably require in order for the Plan and Claim Administrator to obtain recovery or reimbursement and not be prejudiced in exercising the foregoing rights set forth in this provision. The participant agrees to, and shall, cooperate fully with the Plan and the Claim Administrator at every stage, including, but not limited to, claims investigation, recovery efforts, and court or administrative proceedings.

Limitation on Lawsuits and Legal Proceedings

No participant shall bring any legal action against the Employer and/or the Claim Administrator regarding benefits, claims submitted, to compel payment of benefits or any other matter concerning the participant's coverage under the Plan until the earlier of: (1) 60 days after the Claim Administrator has received or waived proof of claim described in subsection "Proof of Claim" or (2) the date the Claim Administrator denies payment of benefits for a claim. Action can be brought earlier if waiting will result in prejudice against a participant. However, the mere fact that a participant has to wait until the earlier of the above is not considered prejudicial. No action can be brought more than three years after the time the Claim Administrator requires written proof of claim.

Direct Payments and Recovery

1. Direct Payment of Benefits.

Unless otherwise specifically stated in the Plan, the Claim Administrator has the option of paying benefits either directly to the physician, hospital or other health care provider, or to the covered employee as described in subsection "Claims Processing Procedure". Payments for covered expenses for which the Employer is liable may be paid under another group or franchise plan or Plan arranged through the covered employee's employer, trustee, union or association. If so, the Claim Administrator can discharge the Employer's liability by paying the organization that has made these payments. In either case, such payments shall fully discharge the Employer from all further liability to the extent of benefits paid.

2. Recovery of Excess Payments.

If the Claim Administrator pays more benefits than what the Employer is liable to pay for under the Plan, including, but not limited to, benefits paid in error by the Claim Administrator, the Claim Administrator can recover the excess benefit payments from any person, organization, physician, hospital or other health care provider that has received such excess benefit payments. The Claim Administrator can also recover such excess benefit payments from any other insurance company, service plan or benefit plan that has received such excess benefit payments. If the Claim Administrator cannot recover such excess benefit payments from any other source, it can also recover such excess benefits payments from a covered employee. When the Claim Administrator requests that the covered employee pay the Claim Administrator an amount of the excess benefit payments, the covered employee agrees to pay the Claim Administrator such amount immediately upon the Claim Administrator's notification to the covered employee. The Claim Administrator may, at its option, reduce any future benefit payments for which the Employer is liable under the Plan on other claims by the amount of the excess benefit payments, in order to recover such payments. The Claim Administrator will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by the Claim Administrator.

Claims Processing Procedure

1. Definitions.

Correctly filed claim: a claim that includes: (a) the completed claim forms if required by the Claim Administrator; (b) the actual itemized bill for each health care service; and (c) all other information that the Claim Administrator needs to determine the Plan's liability to pay benefits, including but not limited to, medical records and reports.

Incomplete claim: a correctly filed claim that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, or subrogation questionnaire.

Incorrectly filed claim: claim that is filed that lack information which enables the Claim Administrator to determine what, if any, benefits are payable under the terms and conditions of the Plan. Examples would include, but are not limited to, claims filed that are missing procedure codes, diagnosis or dates of service.

2. Procedures.

Benefits payable under the Plan will be paid after receipt of a correctly filed claim or utilization review request. The Claim Administrator will notify a participant of its decision on the participant's claim as follows:

a. Concurrent Care. Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for a participant to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a benefit change or termination of the Plan.

Request to extend a pre-authorized treatment that involves urgent care must be responded to within 24 hours or as soon as possible if a participant's condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

b. Pre-Service Claims. A pre-service claim is any claim for a benefit under the Plan which requires prior approval or precertification before obtaining medical care. For prescription legend drugs, submission of a prescription to a pharmacy or pharmacist will not constitute a claim for benefits under the terms and conditions of the Plan. Claims made after 4:00 PM will be logged in and handled on the next business day.

(1) Urgent Pre-Service Claims. Within 72 hours of receipt of an urgent pre-service claim or as soon as possible if a participant's condition requires a shorter time frame. Such claim maybe submitted by telephone, electronic facsimile (i.e. fax) or mail. An urgent pre-service claim is a claim for services for emergency medical care as defined in the Plan.

If the claim is an incomplete claim or incorrectly filed claim, the Claim Administrator will notify the participant of the specific information needed with 24 hours. The participant will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of the Claim Administrator's receipt of the additional information, the Claim Administrator will give its decision on the claim. If the participant fails to provide the information requested by the Claim Administrator, we will provide the participant with its decision on the claim based on the most current information that the Claim Administrator has within 48 hours of the end of the period that the participant was given to provide the information.

If the participant fails to follow this procedure for prior approval or precertification requests, the Claim Administrator will notify him/her within 24 hours of the Claim Administrator's receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining prior approval or precertification.

(2) Non-Urgent Pre-Service Claims. Within 15 days of receipt of a non-urgent pre-service claim.

If the claim is an incomplete claim or incorrectly filed claim, the Claim Administrator will notify you of a 15 day extension and the specific information needed. The participant will then have 45 days from the receipt of the notice to provide the requested information. Once the Claim Administrator receives the additional information, the Claim Administrator will make its decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 15-day period. For example, if the Claim Administrator's notification was sent to the participant on the fifth day of the first 15-day period, the Claim Administrator would have a total of 25 days to make a decision on the participant's claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on the participant's claim exceed 75 days from the date the Claim Administrator received the non-urgent pre-service claim.

If the participants fails to follow the Plan's procedure for prior approval or precertification requests, the Claim Administrator will notify the participant within five days of the Claim Administrator's receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining prior approval or pre-authorization.

c. Post-Service Claims. A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim within 30 days of receipt of the claim.

If the claim is an incomplete claim or incorrectly filed claim, the Claim Administrator may notify the participant of a 15 day extension and the specific information needed. The participant will then have 45 days from the receipt of the notice to provide the requested information. Once the Claim Administrator receives the additional information, the Claim Administrator will make its decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 30-day period. For example, if the notification was sent to the participant on the fifth day of the first 30-day period, the Claim Administrator would have a total of 40 days to make a decision on the participant's claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on the participant's claim exceed 90 days from the date the Claim Administrator received the post-service claim.

If benefits are payable on charges for services covered under the Plan, payment of such benefits shall be made directly to the hospital, physician or other provider providing such services, unless a participant has paid the charges and submitted paid receipts therefore to the Claim Administrator before benefits are paid. The Claim Administrator will send the participant written notice of the benefits paid on his/her behalf. If a participant paid the charges and is seeking reimbursement, payment of such benefits will be made directly to the participant.

If the claim is denied in whole or in part, the participant will receive a written notice from the Claim Administrator with (1) the specific reasons for denial or partial denial is based; (2) the specific references to the Plan provisions on which denial or partial denial is based; (3) a description of additional material or information which may be necessary for the participant to perfect his/her claim and an explanation of why such material or information is necessary; and (4) an explanation of how the participant may have the claim reviewed by the Claim Administrator if he/she does not agree with the denial or partial denial.

Claim Appeal Procedure

A participant may appeal the denial of a claim or utilization review decision by following these procedures:

1. File a written request with the Claim Administrator for a full and fair review of the claim by the Plan;

2. Request to review documents pertinent to the administration of the Plan; and

3. Submit written comments and issues outlining the basis of his/her appeal.

A request for a review must be filed with the Claim Administrator within 180 days after receipt of the claim denial. If the participant's request for review is not received within 180 days, his/her right to appeal the claim denial is forfeited.

If the participant's request for review is received within 180 days. a full and fair review of the claim will be held by the Claim Administrator. The review will not give weight to the initial claim decision. If the appeal involves a decision of medically necessary, a medical consultant that has the appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a health care service, a medical consultant that has the appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed.

After the review, the decision will be made to the participant in writing. It will include the specific reasons for the decision as well as the specific references to the Plan provisions on which the decision is based. The participant will be notified of the Plan decision as follows:

1. For urgent care claims, within 72 hours or as soon as possible if the participant's condition requires a shorter time frame;

2. For pre-service claims, within 30 days or as soon as possible if the participant's condition requires a shorter time frame; or

3. For post-service claims, within 60 days.

An expedited appeal process is available for urgent care cases.

The participant may have representation during the review process.

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

The Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications have or will become effective as required by applicable provisions of the Privacy and Security Regulations.

First, under HIPAA Privacy Regulations, the Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. Subsection "Use and Disclosure of Protected Health Information Under HIPAA" of this section specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the uses and disclosures that the Plan Sponsor may make of your PHI.

The Plan agrees that it will only disclose your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in subsection "Use and Disclosure of Protected Health Information Under HIPAA" of this section have been adopted and the Plan Sponsor agrees to abide by these terms.

The HIPAA Privacy Regulation provision of the Plan took effect April 14, 2004.

Second, under HIPAA Security Regulations, the Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan.

Use and Disclosure of Protected Health Information Under HIPAA Privacy and Security Regulations

The Plan will use your protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose your PHI for purposes related to health care treatment, payment for health care and health care operations. Additionally, the Plan will use and disclose your PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share your PHI with the Plan Sponsor, and limits the uses and disclosures that the Plan Sponsor may make of your PHI.

The Plan shall disclose your PHI to the Plan Sponsor, only to the extent necessary for the purposes of the administrative functions of treatment, payment for health care or health care operations.

The Plan Sponsor shall use and/or disclose your PHI only to the extent necessary for the administrative functions of treatment, payment for health care or health care operations which it performs on behalf of the Plan.

The Plan agrees that it will only disclose your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the use and disclosure of your PHI:

1. The Plan Sponsor will only use and disclose your PHI (including electronic PHI) for Plan administrative functions, as required by law or as permitted under the HIPAA regulations. Your Plan's nNotice of Privacy Practices also contains more information about permitted uses and disclosures of PHI under HIPAA;

2. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

3. The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide your PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to your PHI;

4. The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide electronic PHI to agree to implement reasonable and appropriate security measures to protect electronic PHI;

5. The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor benefits or employee benefit plans;

6. The Plan Sponsor will promptly report to the Plan any impermissible or improper use or disclosure of PHI not authorized by the Plan documents;

7. The Plan Sponsor will report to the Plan any security incident with respect to electronic PHI of which the Plan Sponsor becomes aware;

8. The Plan Sponsor will allow you or the Plan to inspect and copy any PHI about you contained in the designated record set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that you and the Plan must follow and also sets forth exceptions;

9. The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of your PHI contained in the designated record set to the extent permitted or required under the HIPAA Privacy Regulations;

10. The Plan Sponsor will keep a disclosure log for certain types of disclosures set forth in the HIPAA Regulations. You have a right to see the disclosure log. The Plan Sponsor does not have to maintain a log if disclosures are for certain Plan-related purposes such as payment of benefits or health care operations;

11. The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of your PHI available to the Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

12. The Plan Sponsor must, if feasible, return to the Plan or destroy all your PHI that the Plan Sponsor received from or on behalf of the Plan when the Plan Sponsor no longer needs your PHI to administer the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible;

13. The Plan Sponsor will provide that adequate separation exists between the Plan and the Plan Sponsor so that your PHI (including electronic PHI) will be used only for the purpose of plan administration; and

14. The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of your PHI to carry out functions for which the information is requested.

The following employees, classes of employees or other workforce members under the control of the Plan Sponsor may be given access to your PHI for Plan administrative functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section: the Plan Sponsor's Human Resource Department or any employee with oversight responsibility for claims administration.

This list includes every employee, class of employees or other workforce members under the control of the Plan Sponsor who may receive your PHI. If any of these employees or workforce members use or disclose your PHI in violation of the terms set forth in this section, the employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to you.

DEFINITIONS

Administrative simplification: the section of the law that addresses electronic transactions, privacy and security. The goals are to:

1. Improve efficiency and effectiveness of the health care system;

2. Standardize electronic data interchange of certain administrative transactions;

3. Safeguard security and privacy of protected health information;

4. Improve efficiency to compile/analyze data, audit, and detect fraud; and

5. Improve the Medicare and Medicaid programs.

Business associate (BA) in relationship to a covered entity (CE): a BA is a person to whom the CE discloses protected health information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, third party administrators, health care clearinghouses, data processing firms, billing firms and other covered entities. This excludes persons who are within the CE's workforce.

Covered entity (CE): one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated record set: a set of records maintained by or for a covered entity that includes a covered persons' PHI. This includes medical records, billing records, enrollment, payment, claims adjudication and case management record systems maintained by or for the Plan. This also includes records used to make decisions about covered persons. This record set must be maintained for a minimum of six years.

Disclose or disclosure: the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic protected health information (electronic PHI): individually identifiable health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of protected health information.

Health care operations: general administrative and business functions necessary for the CE to remain a viable business. These activities include:

1. Conducting quality assessment and improvement activities;

2. Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;

3. Evaluating health care professional and health plan performance;

4. Training future health care professionals;

5. Insurance activities relating to the renewal of a contract for insurance;

6. Conducting or arranging for medical review and auditing services;

7. Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;

8. Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;

9. Contacting of health care providers and patients with information about treatment alternatives and related functions that do not entail direct patient care; and

10. Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually identifiable health information: information that is a subset of health information, including demographic information collected from a participant, and that:

1. Is created by or received from a covered entity;

2. Relates to the past, present or future physical or mental health or condition of a covered person, the provision of health care or the past, present or future payment for the provision of health care; and

3. Identifies the covered person or with respect to which there is reasonable basis to believe the information can be used to identify the covered person.

Payment: the activities of the health plan or a business associate, including the actual payment under the policy or contract; and a health care provider or its business associate that obtains reimbursement for the provision of health care.

Plan Sponsor: your employer.

Plan administrative functions: administrative functions of payment or health care operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official: the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a covered person's privacy.

Protected health information (PHI): individually identifiable health information transmitted or maintained by a covered entity in written, electronic or oral form. PHI includes electronic PHI.

Treatment: the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use: means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

If you have any questions on the information contained in this booklet, please do not hesitate to contact:

WPS Administrative Services
1717 West Broadway
P.O. Box 8190
Madison, Wisconsin 53708

Phone: Please call the number shown on your Plan Identification Card
Website: www.wpsic.com

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Life and Disability and out-of-state Medical benefits underwritten by:

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