

Department of Employee Trust Funds
STANDARD PLANS
Changes Effective January 1, 2007

New language is highlighted in grey and language that has been removed has been struck out.

1. DEFINITIONS.

The following definitions have been added or revised:

BENEFITS mean payments for HOSPITAL SERVICES, PROFESSIONAL SERVICES and OTHER SERVICES under the HEALTH BENEFIT PLAN. For purposes of the lifetime maximum benefit limit, BENEFITS shall include all payments made under the prescription legend drug program.

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

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

DEPENDENT means the spouse of the SUBSCRIBER and his or her unmarried children (including legal wards who become legal wards, but not temporary wards, of the SUBSCRIBER prior to age 19, adopted children or children placed for adoption as provided for in Wis. Stats. § 632.896, and stepchildren), who are dependent on the SUBSCRIBER (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a DEPENDENT for federal income tax purposes (whether or not the child is claimed), and children of those dependent children until the end of the month in which the dependent child turns age 18. Adoptive children become DEPENDENTS when placed in the custody of the parent as provided by Wis. Stat. § 632.896. Children born outside of marriage become DEPENDENTS of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health and Family Services or equivalent if the birth was outside the State of Wisconsin. The EFFECTIVE DATE of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. A spouse and stepchildren cease to be DEPENDENTS at the end of the month in which a divorce decree is entered. Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards. Other children cease to be DEPENDENTS at the end of the CALENDAR YEAR in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

1. Children age 19 or over who are full-time students, if otherwise eligible (that is, continues to be a DEPENDENT for support and maintenance and is not married), cease to be DEPENDENTS: (1) at the end of the CALENDAR YEAR in which they cease to be full-time students or in which they turn age 25, whichever occurs first; or (2) at the end of the month in which they cease to be dependent for support and maintenance or marry, whichever occurs first.
2. Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, the term "school" includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools, intersession courses (for example, courses during winter break), night schools and student commitments after the semester ends, such as student teaching.
3. If otherwise eligible children are, or become, incapable of self-support on account of a physical or mental disability, which can be expected to be of long-continued or indefinite duration of at least one year or longer, they continue to be or resume their status of DEPENDENTS regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible DEPENDENT under this program in order to resume coverage. The PLAN will monitor mental or physical disability at least annually, but will only terminate coverage prospectively upon determining the DEPENDENT is no longer so disabled, and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the initial PLAN determination.
4. A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes covered under the Plan as an eligible EMPLOYEE.
5. Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of eligibility, not on the date of notification to the Plan.

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

1. requires approval that has not been granted by the appropriate federal or other governmental agency such as, but not limited to, the federal Food and Drug Administration (FDA); or
2. isn't yet recognized as acceptable medical practice throughout the United States to treat that ILLNESS or INJURY.
3. is the subject of either: (1) a written investigational or research protocol; or (2) 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 (3) an ongoing phase I, II or III clinical trial, except as required by law; or (4) an ongoing review by an Institutional Review Board (IRB); or

4. doesn't have either: (1) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (2) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning such treatment, service or supply and reflecting its recognition and reproducibility by non-affiliated sources we determine to be authoritative.

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

1. whether the HEALTH CARE SERVICE is commonly performed or used on a widespread geographic basis;
2. whether the HEALTH CARE SERVICE is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States;
3. the failure rate and side effects of the HEALTH CARE SERVICE;
4. whether other, more conventional methods of treating the ILLNESS OR INJURY have first been exhausted by the PARTICIPANT;
5. whether the HEALTH CARE SERVICE is MEDICALLY NECESSARY;
6. whether the HEALTH CARE SERVICE is recognized as not EXPERIMENTAL or INVESTIGATIVE by MEDICARE, Medicaid and other third party payers (including insurers and self-funded plans).

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

1. consistent with the symptom(s) or diagnosis and TREATMENT of the PARTICIPANT'S ILLNESS or INJURY;
2. appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY;
3. not solely for the convenience of the PARTICIPANT, PHYSICIAN, HOSPITAL or other HEALTH CARE PROVIDER;
4. the most appropriate HEALTH CARE SERVICE which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner and supported by information contained in a PARTICIPANT'S medical record or from other relevant sources.

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

2. **BENEFITS**

The following benefits have been added or revised:

- **Lap band gastroplasty** has been removed from the list of non-covered surgical services.
- *With respect to outpatient AODA/N & M. providers:*

Such TREATMENT must be provided by a PHYSICIAN, a licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or who is certified by the American Board of Professional Psychology, a facility established and maintained according to rules promulgated under Wis. Stats. § 51.42 (7) (b), or a medical clinic or billed by a psychologist under the direction of a PHYSICIAN.

- *With respect to outpatient cardiac rehabilitation:*

BENEFITS are payable for OUTPATIENT cardiac rehabilitation SERVICES. SERVICES must be approved by WPS and provided in an OUTPATIENT department of a HOSPITAL, in a medical center or clinic program. This BENEFIT applies only to PARTICIPANTS with a recent history of:

- a. a heart attack (myocardial infarction);
- b. coronary bypass surgery;
- c. onset of angina pectoris;
- d. heart valve surgery;
- e. onset of decubital angina;
- f. onset of unstable angina;
- g. percutaneous transluminal angioplasty; or
- h. any other condition for which WPS determines cardiac rehabilitation as being appropriate for treating a PARTICIPANT'S medical condition.

BENEFITS are payable only for eligible PARTICIPANTS who begin an exercise program immediately following their HOSPITAL CONFINEMENT for one of the conditions shown above. BENEFITS are limited to CHARGES for up to a maximum of 78 sessions per ILLNESS beginning with the first session in the supervised and monitored OUTPATIENT exercise program. Immediately is herein defined as commencing within three months following the date of SERVICE of the procedure. This time frame may be extended if individual circumstances warrant and are documented as MEDICALLY NECESSARY.

BENEFITS are not payable for behavioral or vocational counseling. The BENEFIT limit stated above is available following a subsequent period of hospitalization for any of the conditions listed in this paragraph. No other BENEFITS for OUTPATIENT cardiac rehabilitation SERVICES are available under this CONTRACT.

- BENEFITS are payable CHARGES for immunizations including, but not limited to, the following: diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; prevnar, and varicella. Immunizations for travel purposes are not covered. The annual DEDUCTIBLE and COINSURANCE amounts do not apply to immunizations provided to PARTICIPANTS to age six.
- BENEFITS are payable for services provided by a nurse midwife when the services are performed in a clinic or hospital setting.
- BENEFITS are payable for Intrauterine devices (IUD); diaphragms, and injections of medication for birth control, and related HEALTH CARE SERVICES. Subdermal contraceptive implants (Norplant) are not covered.
- *Added pacemaker and defibrillator to the list of covered implantations under the TRANSPLANTATIONS, IMPLANTATIONS AND DRAFTING benefit*

3. **EXCLUSIONS**

The following exclusions have been added or revised:

- *With respect to TRANSPLANTATIONS, IMPLANTATIONS AND GRAFTING:*
 - * BENEFITS are not payable for any form of or SERVICES related to TRANSPLANTATION, IMPLANTATION or GRAFTING other than those specifically listed in this Section VIII. This applies even if MEDICARE pays for any portion of the CHARGES.
 - * *Cochlear implants has been added to the list of exclusions*
- CUSTODIAL CARE or rest cures, wherever furnished, and care in custodial or similar institutions, a health resort, spa or sanitarium. This applies even if MEDICARE pays for any portion of the CHARGES.
- Preparation, fitting or purchase of eye glasses or; contact lenses, except as specifically stated in the PLAN; vision therapy, including orthoptic therapy and pleoptic therapy; or eye refractive surgery; hearing aids or examinations for their prescription, except as specifically covered under the PLAN.
- HEALTH CARE SERVICES provided by a midwife, except when provided in a clinic or hospital setting.
- HEALTH CARE SERVICES used in educational or vocational training or testing.

4. **PREAUTHORIZATION:**

The following is added to PREAUTHORIZATION:

- Pain injections such as epidural injections, facet injections or trigger point injections.

5. **TERMINATION OF INDIVIDUAL COVERAGE**

The following is revised and/or added to Termination of Individual Coverage:

4.
 - a. Except when coverage is cancelled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the EMPLOYER is not notified of the PARTICIPANT'S loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS meet the definition of EMPLOYEE or ANNUITANT or DEPENDENT may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the EMPLOYER notice, whichever is later. Application must be received by the DEPARTMENT post-marked within 60 days of the date the PARTICIPANT is notified by the EMPLOYER of the right to continue or 60 days from the date coverage ceases, whichever is later. WPS shall bill the continuing PARTICIPANT directly for the required PREMIUMS. WPS may not apply a surcharge to the PREMIUM, even if otherwise permitted under state or federal law.
 - b. Such PARTICIPANT may also elect to convert to individual coverage, without underwriting, if application is made directly to the PLAN within 30 days after termination of group coverage as provided under Wis. Stat. 632.897. The PARTICIPANT shall be eligible to apply for the direct pay conversion contract then being issued provided coverage is continuous and the PREMIUMS then in effect for the conversion contract are paid without lapse. The PLAN must notify a PARTICIPANT at least 60 days prior to loss of eligibility for COBRA coverage and will also notify the PARTICIPANT of other available options including the availability of conversion coverage and HIRSP. This does not include termination of coverage due to non-payment of PREMIUM. The right to a conversion contract will also be offered when the PARTICIPANT reaches the maximum length of continuation for group coverage.
5. Children born or adopted while the parent is continuing group coverage may be covered for the remainder of the parent's period of continuation. A PARTICIPANT who has SINGLE COVERAGE must elect FAMILY COVERAGE within 60 days of the birth or adoption in order for the child to be covered. The PLAN will automatically treat the child as a qualified DEPENDENT as required by COBRA and provide any required notice of COBRA rights.

The existing numbers 5. and 6. are renumbered to 6. and 7., respectively.