

I. SCHEDULE OF BENEFITS

All benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. Uniform Benefits and this Schedule of Benefits are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of Your coverage and certain rules, if any, You must follow to obtain covered services. In some situations (for example, Emergency services received from a Non-Plan Provider), benefits will be determined according to the Usual and Customary Charge. A change to another Health Plan will result in all benefit maximums restarting at \$0 with the exception of the prescription annual out-of-pocket maximum. This does not include dental and orthodontia benefits that Health Plans may offer that are not a part of Uniform Benefits.

The Group Insurance Board has decided to utilize a PBM to provide prescription drug benefits formerly provided directly by the Health Plans and Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits. The prescription drug benefits are dependent on being insured under the State of Wisconsin Group Health Insurance Program.

NOTE: *Employees and retirees of participating local governments that have selected the deductible option have an up-front deductible of \$500 per individual / \$1,000 per family, per calendar year for all medical services except for preventive services required under Section III., A., 5., i.. Benefits administered by the PBM do not apply toward the deductible. After the deductible is met, Uniform Benefits are administered as outlined below.*

NOTE: *For Participants enrolled in a Preferred Provider Plan (WEA Trust PPPs and WPS Metro Choice), this Schedule of Benefits applies to services received from Plan Providers. Your Health Plan will provide You with a supplemental Schedule of Benefits that will show the level of benefits for services provided by Non-Plan Providers.*

Except as specifically stated for Emergency and Urgent Care (see sections III., A., 1. and 2.), You do not have coverage for services from Non-Plan Providers unless you get a Prior Authorization from your Health Plan. Prior Authorization requirements are described in the Health Plan Descriptions

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section of the “It’s Your Choice: Decision Guide.”

The covered benefits that are administered by the Health Plan are subject to the following:

- Policy Coinsurance and medical Copayments: as described below.

Benefit	Participating Wisconsin Public Employer’s eligible Participants
Routine, preventive services	100%
Illness/injury related services	100%
Emergency Room Copay (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	\$60
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% to an annual OOPM of \$500 per Participant
Cochlear Implants for Participants age 18 and older	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use.
Cochlear Implants Participants under age 18	100% hospital, device, surgery for implantation and follow-up sessions to train on use.
Hearing Aids for Participants age 18 and older	80% to \$1,000 per aid
Hearing Aids for Participants under age 18	100%

- Policy Deductible: NONE.
- Lifetime Maximum Benefit on All Medical and Pharmacy Benefits: NONE.
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: NONE.
- Outpatient Physical, Speech and Occupational Therapy Maximum: Covered up to 50 visits per Participant for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be available when Prior Authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per Participant per calendar year.

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- Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan and hospital charges. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable as described in the preceding grid.
- Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum payment of \$1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum. As required by Wis. Stat. §632.895 (16), hearing aids for Participants under 18 years of age are payable as described in the preceding grid and the \$1,000 limit does not apply.
- Home Care Benefits Maximum: 50 visits per Participant per calendar year. 50 additional Medically Necessary visits per Participant per calendar year may be available when authorized by the Health Plan.
- Hospice Care Benefits: Covered when the Participant's life expectancy is six months or less, as authorized by the Health Plan.
- Transplants: Limited to transplants listed in Benefits and Services section.
- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.
- Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.
- Vision Services: One routine exam per Participant per calendar year. Non-routine eye exams are covered as Medically Necessary. (Contact lens fittings are not part of the routine exam and are not covered.)
- Oral Surgery: Limited to procedures listed in Benefits and Services section.

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- Temporomandibular Disorders: The maximum benefit for diagnostic procedures and non-surgical treatment is \$1,250 per Participant per calendar year. Intraoral splints are subject to the Durable Medical Equipment Coinsurance (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.
- Dental Implants: Following accident or injury, up to a maximum payment of \$1,000 per tooth.
- Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services section. However, each Health Plan may choose to provide a dental plan to all of its members.

The benefits that are administered by the Pharmacy Benefit Manager (PBM) are subject to the following:

- Prescription Drugs and Insulin:

Level 1* Copayment for Formulary Prescription Drugs: \$ 5.00

Level 2** Copayment for Formulary Prescription Drugs: \$15.00

Level 3 Copayment for Covered Non-Formulary Prescription Drugs: \$35.00

Annual Out-of-Pocket Maximum (The amount You pay for Your Level 1 and Level 2 prescription drugs and insulin):

- \$410 per individual or \$820 per family for all Participants, except:
- No annual out-of-pocket maximum for Participants enrolled in the Standard Plan or State Maintenance Plan (SMP)

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

- Disposable Diabetic Supplies and Glucometers Coinsurance: Payable at 80%, which will be applied to the prescription drug annual out-of-pocket maximum.
- Smoking Cessation: One consecutive three-month course of pharmacotherapy covered per calendar year.

*Level 1 consists of Formulary Generic Drugs and certain low cost Brand Name Drugs.

**Level 2 consists of Formulary Brand Name Drugs and certain higher cost Generic Drugs.