Physicians Plus

Employer Group Administrative Manual

Table of Contents

I. Welcome to Physicians Plus

At Physicians Plus, we keep it simple. We believe clear and understandable plans save you time and money. As part of that effort, we offer this guide for health plan administrators. Please read it carefully and feel free to contact our sales department at (608) 282-8940 if you have any questions. We look forward to providing you with exceptional benefits and service.

Please note that this guide is not a statement of policy, and if any changes are made, we will notify you. Please also note that we are not tax advisors and cannot provide tax information or advice. For information about tax issues, please contact an accountant or your business attorney.

Contact Us

A Physicians Plus account executive will work closely with your group, and you can contact that individual directly with most questions. The following contact points are also available:

Phone Numbers

Sales..... (608) 282-8940
Member Services..... (608) 282-8900 or (800) 545-5015
Billing & Enrollment..... (608) 282-8900 or (800) 545-5015
Pharmacy Services..... (608) 260-7803

E-mail Addresses

Sales..... sales@pplusic.com
Group Service..... groupservice@pplusic.com
Member Services..... ppicinfo@pplusic.com

Mailing Addresses

Premium Payments:

Physicians Plus Insurance Corporation
P.O. Box 3057
Milwaukee, WI 53201-3057

Billing, Enrollment and Claims:

Physicians Plus Insurance Corporation
P.O. Box 2078
Madison, WI 53701-2078

Corporate Headquarters:

Physicians Plus Insurance Corporation
2650 Novation Parkway, Suite 400
Madison, WI 53713

Fax Numbers

Member Services..... (608) 327-0321
Billing & Enrollment..... (608) 327-0333
Sales & Group Service ..... (608) 327-0325
Pharmacy Services..... (608) 327-0324

Know Your Plan

Physicians Plus offers plan designs to fit each employer's needs. The plan is comprised of the Corporation Master Policy, summary of benefits, medical certificate and member handbook. Riders and amendments may also be part of the plan, depending upon the group administrator's choices. For a copy of your complete plan, feel free to contact your sales representative. Information is also available online at www.pplusic.com.

Physicians Plus protects your investment. We work with providers to reduce costs, prevent bad billing practices and monitor the quality of care. Our goal is to link members to high quality, low cost medical services. Unfortunately, Physicians Plus cannot check the quality of providers outside our network. We cannot set standards for their costs, billing practices or the quality of care they provide for the benefit of our members. Because of this, we offer information to protect our members from the significant out-of-pocket expenses that can arise when care is sought out-of-network. Most important, our online provider directory tells members how and where to find an in-network provider. Employees can also contact Member Services at (608) 282-8900, (800) 545-5015 or ppicinfo@pplusic.com to find a conveniently located in-network provider. We're here to help!

Choosing a Primary Care Physician

Each member of Physicians Plus Insurance Corporation must choose a primary care physician (PCP) at the time of enrollment.* An up-to-date list of PCPs is available from our online provider directory at www.pplusic.com. Members may change their PCP at any time by contacting Member Services. All PCP changes are effective the first of the month following Physicians Plus notification.

PCP's provide general medical services, refer members to a specialist if necessary, and coordinate a member's overall health care. PCP's are trained to diagnose and treat a wide range of diseases and illnesses. They work directly with specialty providers to coordinate specialized care if needed. Primary care physicians include family practitioners, internal medicine doctors, pediatricians and in some cases, obstetricians/gynecologists.

Family practitioners: Provide medical care for all ages. Some family practitioners provide obstetric care.

Internal medicine physicians: Provide general medical care for adults.

Pediatricians: Provide general medical care for infants, children, adolescents and young adults. Not all pediatricians can be selected as a PCP.

Obstetricians and Gynecologists: Specialize in health care for women, including care during and after pregnancy. Not all OB/GYN physicians allow members to list them as their PCP.

* Does not apply to PPO plan members.

Preventive Services

Most Physicians Plus policies cover preventive screenings and services at no cost. The list is based on the US Preventive Services Task Force list of preventive services and is updated regularly. Members should keep in mind that services that are not considered preventive may still have cost-sharing applied, even if the service is provided in conjunction with preventive services. Members should check www.pplusic.com or contact Member Services for the most current list.

Prior Authorization

Some services obtained from a provider other than the member's PCP require written approval by Physicians Plus before services are provided. This term is frequently referred to as prior authorization.

If prior authorization is required, the provider fills out the information needed on a prior authorization form and sends it to Physicians Plus for approval. Physicians Plus will send a letter to both the member and their provider when a decision is made. If a prior authorization is required but not obtained, Physicians Plus will not pay for the treatment(s), services or supplies provided. All services and benefits are determined at the time of claim; not all services authorized are covered benefits.

The following services are examples of services that DO NOT require prior authorization when an in-network provider delivers services, when medically necessary and the services are a covered benefit, subject to any cost-sharing provisions in the policy:

- Autism, non-intensive therapy services;
- Chiropractic care (long-term care/therapy and/or maintenance care/therapy is not
- covered);
- Dental care (if the Policy includes dental care): members must obtain dental services from an in-network dentist;
- Emergency medical care when the member is outside of the Physicians Plus service area; members must contact Physicians Plus within 48 hours of care;
- Immediate/Urgent medical care with an in-network provider;
- Obstetric and gynecological services performed by an in-network OB/GYN or an in-network, licensed nurse practitioner within the scope of the nurse's license;
- Office visits provided by an in-network PCP;
- Routine eye exams and refractions (one exam and refraction per member per calendar year);
- Routine hearing exams (one exam per member per calendar year); and
- Specialty care not listed below and provided by an in-network provider.

The following are examples of services that DO require prior authorization approved in writing by Physicians Plus prior to obtaining services. This is NOT an all-inclusive list. For a complete list of prior authorization requirements, members should visit www.pplusic.com and click on Member Materials, or contact Member Services.

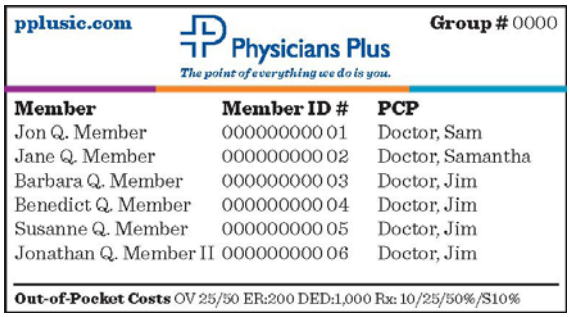
- Any/All treatments, services and supplies being requested and/or performed by any out-of-network provider, including but not limited to: physicians, clinics, hospitals, facilities, DME suppliers and pharmacies (this does not include emergency medical care);
- Acupuncture;
- Hospital or facility admissions: medical & behavioral inpatient and inpatient hospice;
- Hi-tech radiology, such as MRI or MRA.
- Inpatient rehabilitation, skilled nursing facilities or other inpatient care;
- Autism, intensive therapy services: to obtain prior authorization and/or find an in-network provider, contact UW Behavioral Health at (608) 417-4709 or (800) 683-2300;
- Dental care that requires treatment, services or supplies at an outpatient hospital or ambulatory surgery center;
- Genetic testing;
- Home care services, supplies and therapies, including, but not limited to: skilled nursing care;
- Hospice care;

- Outpatient/Ambulatory surgeries/services/procedures that may be considered cosmetic (including, but not limited to: reduction mammoplasties, blepharoplasties, Botox injections and septorhinoplasties);
- Prosthesis, limb (all);
- Rental or purchase of durable medical equipment and supplies, including diabetes supplies (see Summary of Benefits for dollar amounts); and
- Transplants (all).

ID Cards

Once enrolled, employees can expect to receive their ID card in 7–10 business days after the application is processed.

The ID card includes all family members enrolled on the policy, the PCP for each member and the member numbers. The card also includes information on copays, deductibles and coinsurance. All Physicians Plus members receive an ID card at the time of enrollment. Please see the sample ID card below.



Online Resources for Employees

Members can use www.pplusic.com to get the most from their Physicians Plus health plan:

- Connect to MyChart
- Use the WellPlus wellness portal
- Find an in-network doctor in the up-to-date online provider directory
- Review your current prescription drug formulary
- Sign up for the PerkSpot discount program
- Find out all about the 24-7 nurse line, NursePlus
- Access member materials

Emergency Care

Please share this information regarding emergency services with employees who join the plan. Every member has responsibilities, and employees need to know three things about Emergency Room coverage:

1. *The ER is for Emergencies Only* Emergency room (ER) usage is for medical conditions that will likely result in serious jeopardy to the health of a person or unborn child, serious impairment to bodily functions or serious dysfunction of body organs or parts. In Madison, go to Meriter or UW Hospital for emergency care, if possible; review your provider directory for the complete list of in-network emergency care facilities. Non-emergency care received outside the network will not be covered by HMO policies and covered at lower benefit levels for POS and PPO policies.

Some examples of conditions requiring emergency care:

- Choking
- Drug overdose
- Heart attack
- Poisoning
- Seizures
- Serious broken bones
- Severe burns or lacerations
- Severe or unusual bleeding
- Stroke
- Trouble breathing
- Unconsciousness

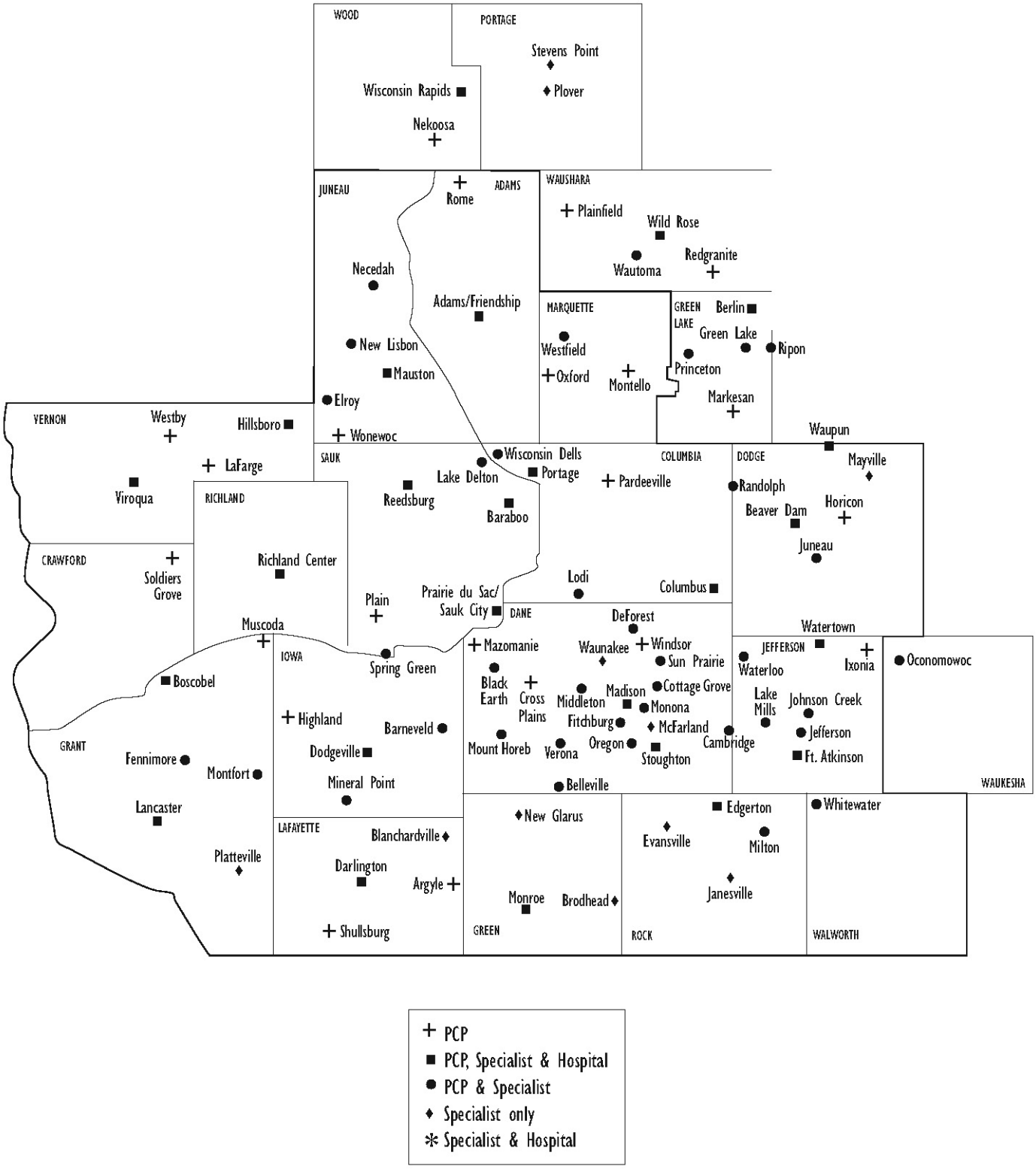
2. *Use In-Network Hospitals, if Possible* Members who require emergency medical care and are in the Physicians Plus service area should seek care at an in-network hospital emergency room when it is safe to do so.

    - If a member cannot safely travel to an in-network hospital and there is a closer out-of-network hospital, they should seek care at the nearest facility.
    - If a member is outside the service area when the emergency occurs, emergency services are covered. Once a member is stable, Physicians Plus will seek to have the member transferred to an in-network hospital. Physicians Plus will coordinate care with the out-of-network hospital for members who cannot be transferred.
    - All Physicians Plus policies include cost-sharing for ER visits. Cost-sharing may include copayment, deductible and coinsurance. Each member's cost-sharing is explained in the Summary of Benefits. In the event a member is readmitted to the hospital within 24 hours for the same illness or injury, Physicians Plus will not apply cost-sharing for the second admission.
    - In some cases, a patient may stay in an observation bed. Observation is not considered a hospital admission. Observation is normally billed by the hospital as an ER visit, and if so, the copayment will apply.

PLEASE NOTE: St. Mary's Hospital in Madison and Janesville, St. Mary's Sun Prairie Emergency Center and Mercy Hospital in Janesville are not part of our provider network. If you receive non-emergency care from any ER facility, it will not be covered by your Physicians Plus HMO policy.

3. *Let Us Know* A member who is admitted to any emergency room must notify Physicians Plus within 48 hours of the admission or as soon as medically possible.

2016 Provider Service Area Map



Policy Exclusions and Limitations

We do not pay benefits for exclusions. We will not pay benefits for any of the services, treatments, items or supplies described in this section, even if any of the following are true: it is recommended or prescribed by a Physician; or it is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in the Medical Certificate of Coverage (Section 6: Benefits and Services) or through a Rider to the Policy.

General Policy exclusions and limitations not listed elsewhere in this Policy are listed in this section. See specific benefits and services for additional exclusions and limitations. The following general exclusions and limitations apply to all services. Physicians Plus will not cover any of the following:

1. Any treatment, service or supply not listed in Section 6: Benefits and Services of the Medical Certificate.
2. Any services for which Prior Authorization was required but not obtained. It is the member's responsibility to obtain the proper Prior Authorizations. For a complete list of Prior Authorization requirements, please visit www.pplusic.com and click on "Member" then "Member Materials" or contact our Member Services department at (608) 282-8900 or (800) 545-5015.
3. Any treatment, services and supplies not specifically identified as being covered under this Policy; and any treatment, services and supplies required in connection with, in follow up to, or as a result of a treatment, service or supply not covered under this Policy.
4. Paternity testing.
5. Cytotoxic testing in conjunction with allergy testing.
6. Hair analysis, unless lead or arsenic poisoning is suspected.
7. Coma stimulation programs.
8. Orthoptics (eye exercise training).
9. Long-term therapy.
10. Massage therapy (except when provided during physical therapy for an Acute illness or injury).
11. A second opinion by a Non-Participating Provider.
12. All eye glasses, contact lenses, sunglasses, and frames except as specifically listed in Section 6: Benefit and Services of the Medical Certificate.
13. Charges for telephone, email and other electronic consultations by and between providers and all related Charges and costs.
14. Charges for any missed appointments.
15. Expenses for medical records and/or reports, including but not limited to, the preparation and presentation of these reports.
16. Chelation therapy for arteriosclerosis.
17. Complications related to cosmetic body piercing, tattooing, implants or other services or procedure that are not medically indicated or not performed by a licensed medical professional.
18. Services and supplies that are not medically indicated and/or are not appropriate or the standard of care to treat the illness or injury, as determined by Physicians Plus.
19. Services and supplies provided while a member's coverage is/was not in effect under this Policy (except as specified in Section 13: Extension of Benefits of the Medical Certificate).

20. Treatment, services and supplies that a third party (other than the member's PCP) requires the member to receive, including but not limited to physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; or required to obtain or maintain a license of any type.
21. Treatment, services and supplies for which another party is liable as determined by Physicians Plus, including, but not limited to: Workers' Compensation, school-based programs, federally mandated programs, Medicare, work-related services including employment physicals, tests, and exams and exams requested or directed by a court of law. If benefits are paid or provided by Physicians Plus whenever this exclusion applies, Physicians Plus reserves all rights to recover the reasonable value of such benefits, including as provided in Section 10: Other Policy Provisions – Direct Payments and Recovery of the Medical Certificate.
22. Services, supplies or other care for injury or illness for which there is non-group insurance (except individual health insurance policies) providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent to the Medical Certificate. This exclusion does not apply to liability insurance policies. (However, coverage commonly referred to as "medical payments" or "med pay expenses" are not liability insurance policies and are covered by this exclusion). If benefits subject to this provision are paid or provided by Physicians Plus, Physicians Plus reserves all rights to recover the reasonable value of such benefits as provided in Section 10: Other Policy Provisions – Subrogation and Reimbursement of the Medical Certificate.
23. Treatment and services for an illness or injury caused by atomic or thermonuclear explosion or resulting radiation, or any type of military action, friendly or hostile.
24. Treatment, services and supplies incurred in connection with any injury or illness arising out of, or in the course of, any employment for which an employer either is required to carry or does carry Workers' Compensation insurance. If Workers' Compensation or any similar law applies to the member, this exclusion applies regardless of whether benefits under Workers' Compensation or any similar law have been claimed, paid, waived or compromised. If benefits are paid or provided by Physicians Plus in a contested Workers' Compensation proceeding, or whenever Workers' Compensation benefits may be payable, Physicians Plus reserves all rights to recover the reasonable value of such benefits as provided in Section 10: Other Policy Provisions – Workers Compensation of the Medical Certificate.
25. Treatment and services furnished by the U.S. Veterans Administration except when coverage is required under applicable federal law.
26. Treatment and services provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or facility or while in the custody of law enforcement officials, except as required by state or federal law. Persons who are injured or become ill while outside of the institution or facility and while on work release are not considered to be held, detained or imprisoned if they are otherwise eligible members.
27. Treatment and services in connection with any illness or injury caused by a member's engagement in an illegal occupation or commission of (or an attempt to commit) a felony. This exclusion does not pertain to services or treatment of injuries that result from a medical condition (such as depression) or from an act of domestic violence.
28. Reconstructive surgery/cosmetic treatment, except as indicated in this Policy. (Note: psychological reasons do not qualify the treatment as medically necessary).

29. Treatment to correct or reverse complications and/or dissatisfaction resulting from surgery, cosmetic treatment, or reconstruction when no functional impairment exists, as determined by Physicians Plus.
30. Injection of filling material such as collagen, salabrasion, rhytidectomy, dermabrasion, chemical peel.
31. Suction-assisted lipectomy.
32. Hair Removal.
33. Mastopexy*.
34. Augmentation mammoplasty*.
35. Correction of inverted nipples*.
36. Sclerosing of spider veins.
37. Panniculectomy.
38. Experimental, investigational, emerging technology treatments, drugs, devices and/or procedure a Physicians Plus medical director deems experimental based on specific evidence. The definition of Specific Evidence can be found in Section 16: Definitions of the Medical Certificate. This exclusion does not apply to treatments mandated by Wisconsin or Federal law.
39. Any treatment, service or supply that is received in a hospital emergency room that does not meet the definition of Emergency Medical Care.
40. Any treatment, service or supply related to the purpose of medical research and/or clinical research trials. This exclusion does not apply to routine patient care that must be covered under Wisconsin State statute §632.87(6)(b) when administered in a cancer clinical trial. This exclusion also does not apply to routine patient care for clinical trials required by Public Health Service Act section 2709(b).
41. Biofeedback (except for stress urinary and colorectal incontinence).
42. Hypnotism.
43. Goal-oriented behavioral modification.
44. Dry Needling.
45. Treatment, services (including saliva hormone testing) and supplies for holistic, complementary or homeopathic medicine, or programs that are not accepted medical practice as determined by Physicians Plus.
46. Treatment, services and supplies (including prescription drugs) for, or leading to, sex-transformation surgery and sex hormones related to such treatment.
47. Sexual dysfunction treatment, services, and supplies including but not limited to implants, penis pumps, vacuum devices, over the counter and prescription drugs.
48. Take-home drugs and outpatient prescription drugs not specifically covered under this Policy.
49. Any service, supply, equipment, medication or other benefit for the treatment of obesity or morbid obesity, except as required by law. This exclusion includes but not limited to: gastric and intestinal bypasses, gastric balloons, stomach stapling, liposuction and wiring of the jaw, liposuction, and weight loss, physical fitness and exercise programs and equipment, even if you have other health conditions that might be helped by the reduction of weight;
50. Nutrition and nutritional supplements and/or vitamins, including infant formula (except when specifically authorized elsewhere in the Medical Certificate).
51. Lodging expenses.
52. Transportation expenses (except for covered ambulance transport as outlined in Section 6: Benefits and Services of the Medical Certificate).
53. Treatment, services and supplies provided by a member or a member’s immediate family or anyone else living with the member.

54. Treatment, services or supplies provided to or received by a member as a collateral in connection with the treatment of any person who is not a member under the Medical Certificate.
55. Treatment, services or supplies for the convenience of the member, the physician, the facility or any other person.
56. Autopsy services.
57. Treatment, services or supplies for which the member has no obligation to pay.
58. When care is provided by a Non-Participating Provider, any amounts in excess of the Maximum Allowed Amount or the usual and customary Charge for the covered service, treatment or supply.
59. Services, supplies and costs (including re-admission) related to services obtained and/or repeated when a member discharges himself or herself and/or leaves a facility or clinic against medical advice as determined by the physician and Physicians Plus.
60. Storage of blood, tissue, cells or any other body fluid except as specifically stated in Section 6: Benefits and Service – Transplants Tissue/Organs of the Medical Certificate.
61. Removal of skin tags.
62. Consultation, treatment, services, prescription drugs and supplies for: infertility treatment and assisted reproduction; artificial insemination (any); direct intrauterine insemination (DIUI); amniocentesis or chorionic villi sampling (CVS) solely for sex determination; consultation or services in connection with in vitro fertilization, embryo transplantation and/or any other reproductive technique such as GIFT or ZIFT; hormone therapy or drugs not approved by Physicians Plus; in vitro fertilization; embryo transfer; freezing or storage of embryo, eggs or semen, reversal of sterilization or related procedures; donor sperm or related services and procedures; sperm enhancement services; any infertility services related to surrogate mother services.
63. Prolotherapy and related services.
64. Charges and expenses incurred before the treatment, service or supply is actually provided to the member, unless a Prior Authorization is obtained.
65. Routine foot care rendered in the absence of localized illness, injury, or symptoms in connection with, but not limited to: (a) the examination, treatment, or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) the cutting, trimming, or other non-operative partial removal of toenails; or (c) for any treatment or services in connection with any of these. This exclusion does not apply to persons requiring routine foot care due to a diabetic condition.
66. Educational programs or services (except diabetes-management classes, chronic-disease-management group or individual classes, and other educational programs and services for which a Prior Authorization is obtained).

* Exclusions marked with an asterisk (*) indicate that the exclusion does not apply in situations where the Women's Health and Cancer Rights Act of 1988 mandates coverage. See Section 6: Benefits and Services —— Surgical Services of the Medical Certificate of Coverage for more information.

Member Services

Our Member Services staff is available at (608) 282-8900, (800) 545-5015 or ppicinfo@pplusic.com from 7 a.m. to 5 p.m., Monday through Friday to answer questions and solve any problems you or your employees may have. Our Member Service department can assist with any of the following questions or concerns:

- Coverage & benefits;
- Selecting or changing a primary care physician;
- Pre-certification and/or referrals for specific services;
- Claims & Eligibility;
- ID Cards & Member materials;
- Change of address and/or telephone number;
- PlusLink & MyChart questions or issues;
- Wellness programs; and
- A complaint or concern.

Privacy Practices for Oral, Written or Electronic Personal Health Information (PHI)

If you have any questions about this notice, please contact the Privacy Officer at (800) 545-5015 or (608) 282-8900.

Physicians Plus' Pledge Regarding Medical Information: Physicians Plus understands and respects the privacy of your medical information. Physicians Plus is required by law to maintain the privacy of "protected health information." Protected health information is information that may identify you and that relates to your past, present or future medical condition and the provision of and payment for your medical care. Physicians Plus maintains safeguards that comply with or exceed current state and federal law to ensure the privacy of your protected health information.

Physicians Plus is required to:

- Maintain the privacy of protected health information and provide you with certain rights in accordance with state and federal law;
- Notify affected individuals following a breach of unsecured protected health information;
- Give you this notice of our legal duties and privacy practices with respect to your protected health information; and
- Abide by the terms of the notice that is currently in effect.

This notice will inform you about the ways Physicians Plus may use and disclose medical information about you and your dependents. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your protected health information.

How Physicians Plus May Use and Disclose Protected Health Information

Notice of Organized Health Care Arrangement: Physicians Plus operates within a clinically integrated setting which is called an organized health care arrangement (OHCA) under the HIPAA Privacy Rule. Participants in the OHCA may share your protected health information (PHI) with other participants in the OHCA for purposes of the health care operations of the OHCA, including (among other things) utilization review and quality assessment and improvement activities. In addition to Physicians Plus, the other participants in the OHCA are the following: Meriter Health Services, Inc., Meriter Medical Group, Inc., Meriter Hospital, Inc., and Meriter Health Enterprises, Inc. (Meriter Home Health and Meriter Laboratories) (collectively "Meriter"). Physicians Plus may share PHI with Meriter for the health care operations of the OHCA. Meriter issues its own, separate notice of privacy practices, and it will abide by the terms of that notice.

Under law, Physicians Plus may use and disclose protected health information without your authorization for purposes of payment, treatment, and health care operations. The following examples show how protected health information is used and disclosed by Physicians Plus for this purpose (this is not an all-inclusive list and not every type of use or disclosure in a category is listed):

Payment: Physicians Plus may use and disclose protected health information for payment of your health and pharmacy claims. We may use and disclose protected health information for purposes of billing, claims

management and determinations of eligibility and coverage for health benefits. For example, in order to make payment for your health care treatment, Physicians Plus will obtain and review claims for services submitted by your health care providers. We may also use and disclose protected health information to determine the medical necessity of specific treatments and for utilization review. For example, we may review your protected health information to determine whether a specific medical procedure is appropriate and consistent with your health condition.

Health Care Operations: Physicians Plus may use and disclose protected health information for health care operations. For example, health care operations include chronic illness management activities, quality assessment activities, legal services and credentialing and review of physicians who provide care for our members. We may also use and disclose your protected health information for certain internal promotional activities. For example, your name, address or e-mail address may be used to send you a newsletter. You may contact our Privacy Officer to request that these materials not be sent to you. Physicians Plus may also use protected health information to contact you regarding health promotion and disease prevention. For example, we might send reminders regarding follow-up examinations, pre-natal and post-natal screenings, counseling on nutrition and exercise, immunization reminders and recommendations regarding heart health, cancer prevention and diabetes health management and other specific health and chronic illness management programs. We may also use and disclose protected health information received at the time of enrollment for underwriting and determining premiums and addressing questions about our insurance products. However, Physicians Plus is prohibited from using or disclosing protected health information that is genetic information for underwriting purposes. In addition to uses and disclosures for its own health care operations, as noted above, Physicians Plus may also use and disclose protected health information for the health care operations of the OHCA that it participates in with Meriter.

Business Associates: Physicians Plus may contract with entities known as Business Associates to perform various functions and provide certain services on our behalf. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or disclose protected health information, but only after they agree in writing to implement appropriate safeguards regarding protected health information. For example, we may disclose protected health information to a Business Associate to perform claims administration services, legal services or pharmacy management services, but any such entity must agree in writing to safeguard protected health information.

State Law: In certain instances, state law imposes limitations on the use and disclosure of protected health information that are more stringent than those imposed by HIPAA. For example, Wisconsin law places restrictions on the use and disclosure of certain mental health, developmental disability, alcohol and drug treatment, and HIV records that are more stringent than the restrictions imposed by HIPAA. When a more stringent state law applies in regard to the use and disclosure of health information, Physicians Plus follows state law.

Other Permitted or Required Uses and Disclosures of Protected Health Information

As Required By Law: We may use or disclose protected health information as required by law so long as the use or disclosure complies with applicable law.

Legal Proceedings: We may use or disclose protected health information in the course of any judicial or administrative proceedings. Physicians Plus may disclose protected health information in response to a court or administrative order. We may also disclose protected health information in response to a subpoena, discovery request or other lawful process, so long as such disclosure complies with applicable law.

Law Enforcement: We may disclose protected health information for law enforcement purposes pursuant to process and as otherwise required by law. Physicians Plus may also disclose protected health information in regard to the following situations: identifying or locating suspects, fugitives, material witnesses or missing persons; in regard to suspected victims of crimes; in regard to a death that may have resulted from criminal conduct; or in regard to possible crimes on our premises.

Worker's Compensation: We may use or disclose protected health information to comply with worker's compensation laws or similar programs.

Disclosures to Benefit Plan Sponsors/Employers: Physicians Plus may disclose health-related information to employers who sponsor group health plans for various purposes. For example, we may disclose summary health information to employers in regard to obtaining premium bids or modifying or terminating a group health plan. We may also disclose enrollment and termination information to employers, including information relating to deductibles, premiums, Medicare and COBRA status. We may disclose protected health information to employers for group health plan administrative functions, such as administering a wellness or other employer-sponsored plan or program. For example, where an employer-sponsored wellness plan provides a benefit to employees who have an annual checkup, we may verify the completion and date of such checkup. In all such instances of disclosing health related information to employers, we will disclose the minimum necessary information to accomplish the intended purpose of the disclosure.

Health Oversight Activities: We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Research: We may disclose your protected health information to researchers when (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and (c) approves the research.

Disclosures with Your Agreement or Opportunity to Object

Individuals Involved in Your Care: In certain circumstances, Physicians Plus is permitted to disclose your protected health information to a family member, relative, close personal friend, or other person you have identified when the person is involved in your care or payment for your care and the disclosure directly relates to the person's involvement. If you are present or otherwise available, we may make such a disclosure if we obtain your agreement, if we provide you with an opportunity to object and you do not object, or if we reasonably infer from the circumstances that you do not object. If you are not present or cannot be provided with an opportunity to agree or object (e.g., because you are incapacitated), we may make such a disclosure if we determine, using our professional judgment, that the disclosure is in your best interest and we disclose only the protected health information that is directly relevant to the person’s involvement with your care. These rules might permit us, for example, to communicate with your spouse regarding payment of a bill in a circumstance where you have not objected to the communication.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by applicable laws or this notice will be made only with your written authorization. Your written authorization is required for most uses and disclosures of protected health information for marketing purposes (as defined in the HIPAA regulations) and disclosures that constitute the sale of protected health information. If you provide authorization for the use or disclosure of protected health information, you may revoke the authorization, in writing, at any time. If you revoke the authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization from that time forward. However, the revocation will not apply to uses or disclosures previously made in accordance with the authorization.

Your Rights Regarding your Protected Health Information

The following are your rights with respect to your protected health information. As you review these rights, please keep in mind that Physicians Plus does not maintain your medical records. To make requests or ask questions about any of these rights, please write Physicians Plus at:

Physicians Plus Insurance Corporation, Attn: Privacy Officer, 2650 Novation Parkway, Suite 400, Madison, WI 53713 OR ppicinfo@pplusic.com.

Right to Inspect and Copy Protected Health Information: You have the right to inspect and obtain a copy of certain protected health information that may be used to make decisions about your health care benefits. To inspect or copy your protected health information, you must submit a written request to the address above. Under law, certain types of protected health information may not be available for inspection or copying, including psychotherapy notes, information compiled in reasonable anticipation of, or use in, any civil, criminal or administrative claim or proceeding, or other information subject to laws that prohibit access. If we deny access to certain protected health information, you may request a review of the decision by writing to the address listed above.

Right to Amend: If you believe that any of your information is incorrect or incomplete, you may ask to have that information amended. You have the right to request an amendment to medical information for as long as the information is maintained. To request an amendment, you must submit your written request, including the reasons that support your requested amendment(s). Physicians Plus will respond to your request in writing within 30 days of receipt and will provide you with further information about your rights in the event we grant or deny your request to amend.

Right to an Accounting of Disclosures: You have the right to receive a written report of certain disclosures we make of your protected health information. The report would not include disclosures made for payment or health care operations as described in this notice, unless the protected health information is maintained as an electronic health record. The report would also exclude disclosures made to you or family members or friends involved in your care or disclosures made according to your signed authorization. The report would include a list of persons or entities to whom information was disclosed, a brief description of the information disclosed and the purpose for the disclosure. If the requested protected health information is maintained electronically, you have the right to request an electronic copy of the information. For information about requesting an accounting of disclosures, please write to the address listed above.

Right to Request Restrictions and Confidential Communications: You have the right to request certain restrictions or limitations on the use or disclosure of protected health information for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. If you would like additional information about your rights on requesting restrictions please contact us at the address listed above. Please note that we are not required to agree to your requested restrictions, except in limited circumstances involving requests for restrictions on disclosures of protected health information related to an item or service that was not paid for by your health plan. You also have the right to request that we communicate with you about protected health information by certain means or at a certain location. We will accommodate such requests to the best of our ability. To request confidential communication changes, you must submit your request in writing to the above address. We may refuse to accommodate your request if you have not provided information as to how payment, if applicable, will be handled or do not specify how or where you wish to be contacted.

Right to Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask for a copy at any time. Even if you agree to receive this notice electronically, you may still request a paper copy of the notice. To obtain a paper copy of this notice, call or write us, or download from www.pplus.com.

Changes to This Notice

We reserve the right to make changes to this notice and to make those changes effective for all protected health information that we maintain. If we make substantive changes to the notice, we will post the revised notice on our web site by the effective date of the changes, and we will provide the revised notice, or information about the changes and how to obtain a revised notice, in our next annual mailing to our members. The effective date of the notice is noted in the upper right hand corner of the first page.

Complaints

If you believe your privacy rights have been violated, you may file a privacy complaint with Physicians Plus or with the Secretary of the Department of Health and Human Services. To file a privacy complaint with Physicians Plus, contact the Privacy Officer at the address listed above. Please note that all other complaints unrelated to privacy must follow the procedures outlined in your Medical Certificate. We will not retaliate against you in any way for filing a complaint.

Gramm-Leach-Bliley Act and Wisconsin Administrative Code Ins. 25

In the process of providing you with health insurance, Physicians Plus may obtain certain personal financial information about you, legally named "nonpublic personal financial information." The Gramm-Leach-Bliley Act of 1999 and Wisconsin Administrative Code INS 25 require us to take steps to protect the confidentiality of your nonpublic personal financial information. To comply, we are providing you with this notice of our privacy policies and practices regarding nonpublic personal financial information. To the extent that federal and state law differs, we will comply with the requirements of the stricter law. We obtain nonpublic personal financial information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with Physicians Plus, our affiliates or others.

Disclosure of nonpublic personal financial information:

- We do not disclose nonpublic personal financial information about our customers or former customers to affiliates or non-affiliated parties, as applicable, except as permitted by law.

Our policies and practices regarding the confidentiality and security of nonpublic personal financial information include:

- We restrict access to nonpublic personal financial information about you to those who need to know that information in order to provide products or services to you.

- We maintain physical, electronic and procedural safeguards that comply with federal and/or state regulations to guard your nonpublic personal financial information.

- We do not sell member lists containing nonpublic personal financial information. In connection with the potential sale or transfer of our business interests, ownership, business or business lines, Physicians Plus reserves the right to sell or transfer your information (including but not limited to your address, name, age, sex, zip code, state and country of residency and other information that you provide through other communications) to a third party entity that (1) concentrates its business in a similar practice or service; (2) agrees to be Physicians Plus's successor in interests with regard to the maintenance and protection of the information collected; and (3) agrees to the obligations of this privacy statement.

- We reserve the right to amend, modify or change at any time and for any reason, our privacy policies and this notice. In any such event, we will provide you with an amended notice.

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

This law affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. It applies both to persons enrolled in group health plans and to persons who have individual health care coverage. In general, plans and health insurance issuers that are subject to NMHPA may <u>not</u> restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth, the period begins at the time of the admission.

The Women's Health and Cancer Rights Act of 1998 (WHCRA)

This federal law provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. It applies, generally, to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does not require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, the plan or issuer is generally subject to WHCRA requirements.

If WHCRA applies to you, and if you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses (e.g., breast implant); and
- Treatment for physical complications of the mastectomy, including lymphedema.

If you have any questions related to the notices included in this brochure, please contact Member Service at (608) 282-8900 or (800) 545-5015.

The Physicians Plus Product Portfolio

Physicians Plus offers a wide variety of plans. If you wish to change plan designs please contact your service representative. The following is an overview of the plan types offered by Physicians Plus.

Health Maintenance Organization (HMO)

An HMO is defined by Wisconsin statute and provides comprehensive medical care. HMOs usually provide access to care from a closed network of providers that are employed by or under contract to the HMO. Care received outside the network is not covered, except in emergency or prior authorized instances.

Point-of-Service (POS)

POS plans use an HMO provider network but also permit members to receive care from out-of-network providers. Out-of-network care is covered at a lower benefit level, so members pay more out-of-pocket.

Preferred Provider Organization (PPO)

The PPO is defined by Wisconsin statute and offers members a preferred national provider network, much like an HMO uses a local network. Members can also choose out-of-network providers, like a POS plan, and pay more out-of-pocket.

II. Eligibility

Employees

A person is an eligible employee if they:

(A) Appear on the Policyholder's regular payroll records (excluding temporary and/or leased employees);
(B) Are scheduled, on average, to perform the duties of his/her job with the Policyholder for at least 20–30 hours per week;
(C) Are actively at work (except where immediate coverage is required under Ins. 6.51 of the Wisconsin Administrative Code or HIPAA); and
(D) Complete the waiting period (not to exceed 90 days), if any, for coverage to be effective as specified by the Policyholder's application for coverage. Any waiting period applied may not exceed 90 days, and the member will be considered enrolled on day 91 after their first date of full time employment.

Dependents

Eligible dependents include any of the following who meet the other requirements of the Policy (such as age limits): a covered employee's spouse; a dependent child, stepchild, adopted child or legal ward who is under age 18; grandchild (so long as the grandchild's parent is a covered dependent and under age 18); a child placed for adoption with the eligible employee; and an adult child described in the following "Federal law" or "Wisconsin law" descriptions.

> Federal law requires insurers to provide coverage of dependent children until age 26. Dependents are eligible regardless of marital status or eligibility for coverage under a group plan offered by the child's employer where the child's premium contribution would be less than the premium amount for their coverage as a dependent under this Policy.
>
> Wisconsin law also requires that coverage be offered for a dependent, regardless of age, who is a full-time student after being called to active duty in the National Guard or a reserve component of the U.S. Armed Services when they were a full-time student under the age of 26.

Effective Dates of Coverage

To be enrolled, coverage must be applied for and approved by Physicians Plus and the required premium must be received by Physicians Plus. Except in cases of continuation coverage, eligible dependents can be covered under this Policy only if the eligible employee is covered. Except for late enrollment (discussed below) and the special enrollment period (discussed below), coverage becomes effective on the following dates:

For an eligible employee, coverage generally becomes effective on the latest of: (A) The effective date of the Corporation Master Policy between Physicians Plus and the Policyholder; and (B) When the employee has satisfied all of the requirements to be an eligible employee, including completion of any waiting period specified by the Policyholder in its application for coverage.

Coverage will be delayed if the eligible employee is not actively at work on the date coverage would otherwise begin (unless that date falls on a non-working day and the employee was actively at work on the

immediately preceding working day or except as required by Ins. 6.51 or HIPAA). If coverage is delayed for this reason, coverage for the eligible employee and their enrolled eligible dependents will begin on the next day the eligible employee is actively at work.

Coverage also will not be effective if the eligible employee fails to apply for coverage: (i) during the Policyholder's annual enrollment period, or (ii) for an employee who was not eligible during the annual enrollment period, within 31 days of beginning work for the minimum number of hours per week that the Policyholder requires for an employee to be eligible for health insurance coverage. In those situations, the employee will be considered to be a late enrollee.

For an eligible dependent, coverage becomes effective on: (A) The date the eligible employee is enrolled for coverage in the case of dependents who then qualify as eligible dependents; (B) The date of the eligible employee's marriage in the case of the spouse and any stepchild acquired on that date; (C) The date of birth of the eligible employee's natural-born child; (D) The date a child is placed for adoption (as defined in Section 632.896(1) of the Wisconsin Statutes) in the eligible employee's home or the date that a court issues a final order granting adoption of the child to the eligible employee, whichever occurs first; (E) The date of the court order appointing the covered employee or their covered spouse as guardian in the case of a legal ward; (F) The date of birth for a child born to an eligible employee's covered child who is under age 18; or (G) The date the adult child returns from serving in the military and becomes a full-time student if the adult child was a full-time student under age 26 when they were called to federal active duty with the National Guard or in a reserve component of the U.S. Armed Forces.

When coverage is first requested under (G) and annually thereafter, Physicians Plus may require documentation that a child meets those criteria for coverage. Except for newborns, adopted children (which is discussed below) and children placed for adoption with the eligible employee (which is discussed below), an application must be received by Physicians Plus within 31 days of eligibility or the individual will be subject to a waiting period unless they are considered for a special enrollment. See "Special Enrollment Events" and "Late Enrollment" below.

Special Enrollment

If an eligible employee or an eligible dependent does not apply for coverage when initially eligible due to having other creditable coverage, they may be eligible for a special enrollment period if: (1) they were covered under other health insurance coverage at the time of initial eligibility; (2) they stated in writing at the time of initial eligibility that other health insurance coverage was the reason for declining enrollment; and (3) they apply for coverage no later than 31 days after the date on which the other coverage is exhausted or terminated.

Special Enrollment Events

Physicians Plus must receive the application for a special enrollment within 31 days of the special enrollment event or the members will be considered late entrants. Please don’t wait for a Certificate of Creditable Coverage to send enrollment forms. Please review the following details regarding special enrollment events; other special enrollment events may apply. If you have questions about a specific event, please contact your account executive.

Event	Guideline	Effective Date	Forms Needed
Marriage	Employee, spouse and newly acquired dependents may apply or employee may add spouse and newly acquired dependents.	Date of Marriage	Group Application/Change Form
Birth	(1) Employee, spouse and newborn may apply, or (2) employee may add spouse and/or newborn, (3) or employee may add spouse, siblings and/or newborn.	Date of Birth of newborn child	Group Application/Change Form
Adoption	(1) Employee, spouse and newborn may apply, or (2) employee may add spouse and/or newborn, (3) or employee may add spouse, siblings and/or newborn.	Date of order for legal adoption or placement.	Group Application/Change Form and copy of court order placing child for adoption.
Legal Ward/Guardian	Employee may add legal ward/guardian to existing coverage.	Date of legal custody or placement of legal ward.	Group Application/Change Form and copy of court order placing child with employee or spouse.
Divorce	Employee and eligible insured dependents may join the group plan if losing coverage due to divorce.	Date following loss of other coverage.	Group Application/Change Form and proof of loss of other coverage (certificate of creditable coverage, letter from previous carrier, continuation notice*).
Loss of other Creditable Coverage, Voluntary or Involuntary	Eligible employee, spouse and dependents may join the group plan.	Day/date following loss of other coverage.	Group Application/Change Form and proof of loss of other coverage (certificate of creditable coverage, letter from previous carrier, continuation notice*).
Significant ($25 single/$50 family per month) increase in cost for spouses plan caused by group or insurer.	Employee and eligible insured dependents may join the group plan if losing coverage.	Date following the effective date of increase in premium for other plan.	Group Application/Change Form and proof of premium increase from other plan.
Move into or out of the service area.	Employee and eligible insured dependents may change from a HMO plan to a POS or PPO plan if they move out of the service area.	First of the month following the move.	Group Application/Change Form

Medically Necessary Leave of Absence from School

This section only applies when the covered dependent had coverage beyond the maximum dependent age as a full-time student after being called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces.

An adult child who was covered as a full-time student shall continue to be eligible for coverage if, due to a medically necessary leave of absence, they cease to be a full-time student.

An adult child is only eligible for this special continuation of coverage if they notify us within thirty (30) days of ceasing to be a full-time student and submit documentation and certification of the medical necessity of the leave of absence from their attending physician. The date the adult child ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which this special continuation coverage begins. The special continuation coverage ends when any of the following happen:

1. The adult child advises Physicians Plus that they do not intend to return to school full time;
2. The adult child becomes employed full time;
3. The adult child obtains other health care coverage;
4. The adult child marries;
5. Coverage of the subscriber through whom the dependent is covered under the Policy is discontinued or not renewed; or
6. One year has elapsed since the adult child special continuation coverage under this provision began and the adult child has not returned to school full time.

Newborns, Adopted Children and Children Placed for Adoption

Newborns: Coverage for a newborn of an eligible employee who is covered under the Policy is effective from the moment of birth. In the event of a newborn, please submit the application for coverage of the newborn to Physicians Plus as soon as possible. If more than one insurance Policy will cover the newborn, please notify all applicable plans as soon as possible.

If Physicians Plus is obligated to cover a newborn, all requirements of the Policy must be satisfied for services to be covered, including authorizations for inpatient services for the birth of the child. An application and any required premiums must be submitted to Physicians Plus within 60 days of the birth or adoption. Coverage of the newborn will terminate after 60 days unless, within one year of the birth, the member applies for coverage and pays Physicians Plus all back premiums plus interest at a rate of 5.5%. If coverage terminates for the newborn, they will be considered a late entrant and may not enroll until the next open enrollment period.

Adopted children and children placed for adoption: Coverage for an adopted child is effective on the date that a court makes a final order granting adoption of the child to the eligible employee. Coverage for a child who is placed in the eligible employee's home for adoption is effective on the date the child is "placed for adoption" as defined in Section 632.896(1) of the Wisconsin Statutes. Physicians Plus must be notified that the child is adopted or placed for adoption and any required premium paid to provide coverage for the child within 60 days or the child will be considered a late entrant and may not enroll until the next open enrollment period.

Medicaid and CHIP

An eligible employee or an eligible dependent may enroll outside the normal enrollment period if: (1) the eligible employee’s or eligible dependent’s coverage under Medicaid or CHIP is terminated as a result of loss of eligibility for that coverage, or (2) the eligible employee or eligible dependent becomes eligible for a Medicaid or CHIP premium assistance subsidy. To qualify for this special rule, the eligible employee or the eligible dependent must request coverage under this Policy within 60 days of the termination of their Medicaid or CHIP coverage or within 60 days after they are determined eligible for the Medicaid or CHIP subsidy.

Late Enrollment

A late enrollee is defined in the law as an individual who attempts to enroll under a plan at any time other than 1) during the period in which he or she is first eligible, or 2) during a special enrollment period. Physicians Plus does not medically underwrite late enrollees to determine whether or not to issue coverage based on their health status.

If an Eligible Employee does not apply for coverage within 31 days of initially becoming eligible for coverage and does not qualify for any of the above special rules for enrollment, the Eligible Employee and Dependent(s) will not be allowed to enroll until the next open enrollment period or 12-months from the application date, whichever is sooner. See the “open enrollment” definition in Section16: Definitions.

It is critical that employees and/or their dependents exercise caution when declining health insurance when it is first available. If coverage is waived, the employee or dependents may be denied coverage if and when they apply for enrollment, unless they qualify for a special enrollment period. Any eligible employee not electing to enroll on your health insurance plan within the probationary period must sign a waiver. Please keep a copy of the waiver for your files and forward the original to our Enrollment Department.

III. Claims

Process

A Member must submit written proof of claim to us within 120 days of occurrence. We must receive:

a. The completed claim forms if required by Physicians Plus;
b. The actual itemized bills for treatment or service; and
c. Any other information needed to determine Physicians Plus liability to pay benefits under the Policy.

Circumstances beyond a member's control might prevent submission of such proof within this time period. So long as the member files the proof of claim as soon as possible, but no later than 120 days after the occurrence, coverage will not be invalidated unless it was reasonably possible to provide the proof of loss earlier and we have been prejudiced by the delayed proof of loss. In all circumstances, Physicians Plus will determine benefits at the time of claim.

Benefits payable under the Policy will be paid as soon as reasonably possible after we receive the required, written proof of claim from the member. We pay claims in the order they are received up to the limits of the policy. We will decide whether benefits are payable on the expenses for covered services submitted to Physicians Plus within a reasonable period of time after Physicians Plus receives the written proof of claim as described under "Proof of Claim" above. Any benefits paid in accordance with the Policy shall fully discharge Physicians Plus from all further liability to the extent of benefits paid.

If benefits are payable on expenses for services covered under the Policy, Physicians Plus will pay such benefits directly to the hospital, physician or other health care provider providing such services, unless the member paid the expenses and submitted proof of payment to Physicians Plus before benefits were paid. If this occurs, reimbursement from Physicians Plus will be made directly to the member.

Benefit accumulators follow the benefit year. For example, if a group plan begins on July 1, all amounts that count toward deductible and maximum out-of-pocket limits will accrue from that July 1 to June 30 of the following year.

If there are circumstances that require Physicians Plus to have more time to determine our liability to pay benefits on a claim, Physicians Plus will send a written notice within 30 days of our receipt of the proof of claim, explaining why additional review time is needed. In that case, our decision on the claim will be made within 120 days of receipt of such proof of claim. An interest payment of 12% per year will be paid on claims not paid within 30 days of our receipt of all information necessary for claim processing.

If benefits are denied, the member will receive a written notice of the denial including:

a) The specific reasons on which denial or partial denial is based;
b) The specific references to the Policy provisions on which denial or partial denial is based;
c) A description of additional material or information that may be necessary for to perfect a claim and an explanation of why such material or information is necessary; and
d) An explanation of how members may have the claim reviewed by Physicians Plus if there is disagreement with a denial or partial denial.

Subrogation

Physicians Plus business partner Optum will pend all claims with a diagnosis common to accident or work-related conditions. Optum will contact the member by telephone or mail to request information to facilitate subrogation against the responsible party.

Upon request, Optum can provide employers with an annual report detailing the financial recoveries for subrogation efforts. Work-related claims are an exclusion; employees should refer to their Medical Certificate of Coverage for more details.

Physicians Plus does not duplicate benefits when another party is financially responsible for an injury or illness (e.g., an auto accident, or accident on another person's private property). Physicians Plus retains the right to recover (subrogate) costs for services rendered when another party may be liable for payment of medical expenses. Please call your account executive if you become aware of situations in which another party is financially responsible for an injured employee.

Worker's Compensation

Physicians Plus does not cover injuries or illnesses covered by Worker's Compensation. The employer's Worker's Compensation carrier should be billed for these charges. However, if benefits are paid by Physicians Plus and it is determined that a member is eligible to receive worker's compensation for the same incident, Physicians Plus has the right to recover any benefits provided. Please see the Medical Certificate of Coverage for detailed information on subrogation and Workers Compensation.

IV. Billing and Enrollment

PlusLink

Use PlusLink, our secure online enrollment tool designed to assist employers in administering their plans. Groups receive log-in information upon initial enrollment. PlusLink allows you to:

- Add new employees and their eligible dependents
- Change subgroup
- Disenroll subscribers and dependents
- Change PCP
- Change address
- Download rosters
- Search invoices
- View benefits
- Send secure messages
- Pay premiums

To learn more, review the online user manual for PlusLink or contact your account executive. If you need assistance with your login, please contact Member Services.

Premium Payments

Send premium payments to:

Physicians Plus Insurance Corporation
PO BOX 3057
Milwaukee, WI 53201-3057

Please include the payment coupon from your invoice and include the group number on your check to ensure proper posting if they are separated.

You may also submit payments online via your PlusLink account or Electronic Funds Transfer (EFT).

The first premium payment is due on or before the Policy effective date. The Policy is in force upon payment of the first month's premium or the stated effective date in the policy, whichever is later. Subsequent premiums are due as-stated.

If the Policyholder fails to pay premiums by the first day of the coverage month, the Policy and its coverage will end on the last day of the grace period. Partial premium payment is not considered payment of premium and will not extend policy coverage or the grace period. The grace period is 31 days after the last premium paid-through date. Premium payment after the grace period does not guarantee coverage. Premiums will be collected for coverage during the grace period.

Physicians Plus reserves the right to request up to two months premium payment in advance for groups re-applying for coverage with Physicians Plus after being terminated due to non-payment of premium.

Adjustments

Please pay your premium as billed. Keep track of additions and deletions, and your bill will be adjusted based on date of the submitted change. If you do not submit payment as-billed, please include discrepancy details.

Reinstatement

If Physicians Plus approves reinstatement, no lapse in coverage will be allowed, and all past-due premiums must be paid in full. In addition to payment of all past-due premiums, a reinstatement fee of $250 will be

assessed. Physicians Plus may require two months premium in advance as a condition of the reinstatement. The two-month premium payment will be applied to the first two months of coverage.

Off-Renewal Rates

Physicians Plus reserves the right to adjust off-renewal rates if there is an increase or decrease in case characteristics of 15% or more. Case characteristics do not include health status and other factors relating to claims experience.

Renewal Notice

Physicians Plus must notify the Policyholder of a change in premium rates at least 30 days before the beginning of any rate change or renewal period. If the rate change is greater than 25 percent, Physicians Plus must notify the Policy Holder at least 60 days before the beginning of any rate change or renewal period.

Effective Dates

If the number of persons covered under this Policy changes after the effective date, premiums will change as follows:

(A) For any addition effective from the 1st through the 15th day of any calendar month, Physicians Plus will bill a full month's premium or change in premium for that person for that month.

(B) For any addition effective on or after the 16th day of any calendar month, Physicians Plus will not bill for that person for that month's premium or change in premium. Physicians Plus will begin billing for that person as of the first day of the succeeding calendar month.

(C) For any termination of coverage effective from the 1st through the 15th day of any calendar month, Physicians Plus will not bill for that person for that month's premium or change in premium.

This applies only if:

(1) The Policy does not indicate that all terminations are effective at the end of the calendar month; or

(2) The termination is due to:
  (a) Death;
  (b) Entry into military service;
  (c) Divorce; or
  (d) Marriage.

For terminations not meeting criteria (1) or (2), above, Physicians Plus will bill a full month's premium or change in premium for that person for that month.

(D) For any termination of coverage effective on or after the 16th day of any calendar month, Physicians Plus will bill a full month's premium or change in premium for that person for that month.

(E) In no case will Physicians Plus consider the effective date of an addition of coverage or a termination of coverage to be more than 60 days prior to the date Physicians Plus is notified of the termination or addition.

(F) Regardless of whether notice has been given and/or premium has been or will be adjusted, coverage for a member will not extend beyond the date coverage should have ended due to loss of eligibility.

Enrollment

If the transaction you need to process is not available on PlusLink, or if you do not have a PlusLink account, it is important to submit the Group Enrollment/Change form in the following situations:

1. Adding a dependent: When adding a dependent (e.g., a spouse or child), Sections 1, 2, 3, 4 and 5 must be completed, including:
   - Dependent's name and address
   - Relationship to employee
   - Social Security number
   - Gender
   - Birthdate
   - Name and provider number of PCP. Please note: a member will not be enrolled without a PCP.
   - Reason for addition, such as marriage, birth or loss of other coverage

   New dependents may be added by submitting a completed change form within 60 days of a birth or adoption or within 31 days of a marriage or special enrollment event. Coverage is effective the date of birth or marriage (see SECTION 9).

2. Terminating a dependent: When terminating a dependent, Sections 1, 2, 4 and 5 must be completed. In Section 3, indicate the effective date of the change, the reason the dependent is being removed from the plan, and check the "Delete dependents listed above" box. Terminating a dependent must be done in writing via the Group Enrollment/Change form.
3. Terminating an employee: Complete Sections 1, 2 and 5. In Section 3, indicate the effective date the employee should be removed from the plan (per the Group Master Policy), the reason for the change and check the "Cancel all coverage" box.
4. Change of birthdate.
5. Legal name change.

To submit the Group Enrollment/Change Form:

1. Complete the form and send the white copy to:

   Physicians Plus Insurance Corporation
   P.O. Box 2078
   Madison, WI 53701-2078

2. Retain the yellow copy
3. Give the pink copy to the employee.

Please note that in no case will Physicians Plus consider the effective date of a termination of coverage to be more than 60 days prior to the date we are notified of the termination.

Ending Coverage

Coverage under this Policy ends on the earliest of the following dates except as described in "Extension of Benefits" section of the Medical Certificate of Coverage:

(A) The date the Policy terminates;
(B) The date the member dies;

(C) The last day of the calendar month for which the member's premium contribution, if any, has been paid;
(D) The date a member enters into military service, other than for duty of less than 30 days;
(E) If a member is absent from work due to an injury or illness, the last day of the calendar month in which the member's status as an employee ends as determined by his/her employer;
(F) For an employee, the last day of the calendar month in which the member ceases to be within the class of employees eligible for coverage under the Policy;
(G) For an employee's spouse and/or other dependent who is a member, the date the employee's coverage terminates;
(H) For the employee's spouse, the date the employee's spouse is no longer married to the employee due to divorce or annulment;
(I) For the employee's eligible dependent child, stepchild, adopted child, or child placed for adoption with the employees to be eligible, the end of the day (12:00/midnight) when the child exceeds the maximum dependent age of 26;
(J) For the grandchild of the covered employee, the date that the grandchild's parent reaches age 18 or otherwise loses coverage;
(K) The date a member is dis-enrolled as described in any section of this Policy; and
(L) For a child that is placed for adoption with the employee but for whom the adoption is not finalized, the date when the child's adoptive placement with the subscriber is terminated.

However, there are two exceptions to coverage terminating when the adult child exceeds the maximum dependent age, if the child otherwise satisfies the coverage requirements.

First, coverage for the child will not terminate if a child, who otherwise satisfies the coverage requirements, is and continues to be both: (i) incapable of self-sustaining employment because of mental or physical handicap and is (ii) chiefly dependent upon the covered employee for support and maintenance. In that situation the adult child may remain eligible under family coverage beyond the maximum dependent age.

Physicians Plus will work with the employee, the adult child and the attending physician to establish the child's mental or physical handicap. Physicians Plus will make the final decision regarding the eligibility of the child. Eligibility will be verified annually.

Second, coverage may continue for an adult child if they are a full-time student after being called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces when they were a full-time student under the age of 27 (see "Effective Dates and Eligibility" section of the Medical Certificate).

Disenrollment

We may terminate a member's coverage and disenroll a member from Physicians Plus coverage for any of the following reasons:

(A) The member failed to pay required premium by the end of the grace period;
(B) The member committed acts of physical or verbal abuse that pose a threat to providers or other Physicians Plus members;
(C) The member has improperly allowed a person other than a member to use a Physicians Plus identification card to obtain services or has knowingly provided fraudulent information in applying for coverage;
(D) The member is unable to establish or maintain a satisfactory physician-patient relationship with the member's PCP;
(E) Physicians Plus has not renewed the Policy; or
(F) The member establishes residence outside of the service area.

Disenrollment for reason (D) shall occur only after Physicians Plus offers the member an opportunity to select an alternate PCP, made a reasonable effort to assist the member in establishing a satisfactory physician-patient relationship and told the member that a grievance may be filed on this matter. If a member is dis-enrolled for reasons (B), (C) or (D), coverage shall continue until the member finds other coverage or until the next opportunity for the member to change insurers, whichever comes first.

Certificate of Creditable Coverage

Any member needing a Certificate of Creditable Coverage may request one from Member Services.

Continuation

Continuation administration is the responsibility of the employer. Continuation coverage and provisions do not apply to individual coverage or coverage NOT provided by an employer.

Please terminate a member as soon as possible after such an event. If the member is eligible for continuation coverage, we can add the member after the required notices are sent and the member elects coverage.

Federal Continuation (COBRA)

A member who is no longer eligible for coverage under the Policy, such as former employees, certain dependent children and divorced or surviving spouses and their dependent children may be eligible for continuation of coverage in accordance with the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, as amended. To the extent COBRA applies to a Policyholder or member, the following provisions apply:

- COBRA requires a member to notify the Policyholder of a divorce or legal separation, the date on which a child ceases to be an eligible dependent that would cause a loss of coverage and within 60 days of such event. The Policyholder then has 14 days to notify the member of the right to elect coverage under COBRA.

- The Policyholder must notify Physicians Plus within 30 days of a subscriber's death, termination, reduction in hours of employment, entitlement to Medicare or the Policyholder's initiation of bankruptcy proceedings.

- Failure to comply with any of these required notice periods may result in a member's ineligibility for COBRA coverage.

COBRA coverage is available for limited periods of time, which vary according to the member's status and the particular circumstances that resulted in loss of eligibility for coverage. Despite these time limits, COBRA coverage will cease when:

(A) The member becomes covered under any other group plan that has no exclusion for pre-existing conditions of the member;
(B) The member becomes entitled to Medicare (in most instances);
(C) Premiums are not paid on a timely basis; or
(D) The Policyholder ceases to maintain any group health plan.

The Member is required to notify the Policyholder if either event (A) or (B) occurs while the member has COBRA coverage.

Wisconsin Continuation

In certain cases, a member may be eligible to continue terminated coverage that would otherwise end under general provisions. Those eligible for continuation of coverage are:

(A) A subscriber who is no longer eligible under the Policy, except if employment is terminated for misconduct on the job; or
(B) A subscriber's spouse or dependent who is no longer eligible under the Policy due to divorce, annulment or death of the subscriber.

In either case, the member must have been covered under the Policy for at least three months prior to the termination date of coverage. Within five days of receiving notice to end a member's coverage, the Policyholder must notify the member of:

(A) The option to continue coverage under this provision or convert coverage as provided under conversion Policy provisions;
(B) The premium amount the member must pay monthly to continue coverage or purchase the conversion Policy;
(C) The manner in which and the place to which the member must make premium payments; and
(D) The time by which the member must pay for continuation of coverage.

Continuation of coverage under the Policy may be continued until the earliest of the following dates:

(A) The date the member becomes eligible for other similar group coverage;
(B) For a member who originally obtained coverage through their former spouse, the date the former spouse is no longer eligible for coverage under the Policy;
(C) The date the Policy terminates;
(D) The date the member moves out of Wisconsin;
(E) The end of the period of time for which the member timely paid premium; or
(F) The end of 18 months after the member elects continuation of coverage.

A member may convert to an individual medical expense conversion Policy when continuation of coverage ends unless continuation of coverage ends because of nonpayment of premium to us as required (see conversion Policy provision).

COBRA/Wisconsin Continuation Chart **If both COBRA and Wisconsin Continuation apply, use the law most favorable to the insured.**		
	COBRA	**Wisconsin Continuation Law**
Which law applies to my company?	This law applies to employer's insurance policies purchased for insured or self-insured group plans, for companies with 20 or more employees. (COBRA does not apply to federal government and church plans.) *(NOTE: when counting employees 2 part time = 1 full time)*	The law regulates the group health insurance policies purchased for all insured group plans, regardless of size, which operate in the state of WI.

COBRA/Wisconsin Continuation Chart If both COBRA and Wisconsin Continuation apply, use the law most favorable to the insured.		
	COBRA	**Wisconsin Continuation Law**
Who does continuation apply to?	Any "qualified beneficiary" who on the day before a "qualifying event" is covered under the group plan and who would lose coverage under the group plan as a result of the qualifying event.	Any of the following persons who have been continuously covered under a group policy for at least 3 months: 1) The former spouse of a covered employee who would lose coverage upon divorce or annulment; 2) The spouse or dependent of the covered employee upon employee's death (if the spouse/dependent also was covered); 3) The covered employee, his or her covered spouse and any covered dependents upon termination of the employee's eligibility, such as termination of employment (unless discharged for "misconduct").
When do I notify?	Upon initial enrollment, each covered employee and his/her spouse must be provided written notice of their continuation rights as provided by COBRA. Upon receiving notification of the occurrence of a qualifying event, the plan administrator (often the employer) must notify qualified beneficiaries of their COBRA election rights within 14 days.	Upon receiving notification to terminate coverage, the employer must provide written notice within 5 days.
How do I know there has been a qualifying event?	The employee/qualified beneficiary is responsible for notifying the plan administrator of a qualifying event within 60 days of the following events: • Divorce or legal separation of a covered employee, or • A dependent child ceasing to be a dependent under the plan. The employer generally must notify the plan administrator of a qualifying event within 30 days of the following events: • Death of the covered employee, • Termination or reduction of hours of the covered employee, • The covered employee becoming entitled to Medicare, or • The bankruptcy of the employer. (However, you are not required to wait until formal notice of a qualifying event is received to send an election notice.)	When the employer is notified to terminate coverage (for example, upon divorce or annulment) or learns of an event resulting in a loss of coverage (for example, termination of the employee's employment or the employee's death), the employer's duty to provide the notification of election rights is triggered.

COBRA/Wisconsin Continuation Chart If both COBRA and Wisconsin Continuation apply, use the law most favorable to the insured.		
	COBRA	**Wisconsin Continuation Law**
When does the election period begin and end?	The election period generally begins on the date of the qualifying event, and ends 60 days after the later of the date of (1) loss of coverage and (2) the date the qualified beneficiary receives notification from the plan administrator.	The election period commences on the date the insured receives notification from the employer and ends 30 days after.
When does continuation coverage begin?	Continuation coverage generally begins on the date of the qualifying event.	At the time coverage would otherwise terminate, coverage continues without interruption, provided the group policy member elects continuation coverage under group policy or conversion to individual coverage and timely pays the required premium.
When does continuation coverage end?	Continuation coverage ends upon the occurrence of specified events, as follows: a. The employer no longer provides group coverage to any employee. b. The insured fails to make timely premium payment. c. The insured becomes covered by another group policy, unless there is a pre-existing clause on the new group plan, after being enrolled under COBRA. d. The insured becomes entitled to Medicare, after being enrolled under COBRA. e. The "maximum required period" ends. The maximum required period generally is 18 months from the date of the covered employee's termination or reduction of hours or 36 months from the date of other qualifying events.	Continuation coverage terminates only upon the occurrence of one of the following: a. The insured establishes residence outside Wisconsin. b. The insured fails to make timely premium payments. c. The insured becomes eligible for another group policy, unless the plan has a pre-existing condition limitation or exclusion. d. When the covered employee ceases to be eligible for coverage, coverage of a former spouse also ends. e. The end of 18 months of continuation coverage, if the insurer requires conversion to individual coverage at any time beginning after 18 months of continuation coverage.
What premiums do I charge?	The premium for any period of continuation coverage may not exceed 102% of the cost to the group plan. (In Wisconsin, the law prohibits premiums of more than 100% of the cost of the group plan.)	The premium for any period of continuation coverage may not exceed the group rate in effect (including the employer's contribution) for a covered employee.
When are premiums paid?	Coverage under the group plan continues uninterrupted if an appropriate election is made and the premium is tendered within 45 days of the election. A grace period of 30 days applies to all subsequent premium payments.	Continuation or conversion coverage, as applicable, continues uninterrupted if an appropriate election is made and the premium is tendered within 30 days after receipt of notification from an employer. There is no grace period for subsequent premium payments.

COBRA ONLY – (WI State Continuation duration of coverage is 18 months regardless of the event).		
COBRA Qualifying Events & Duration of Coverage	• Reduction in hours (full-time to part-time, Strike, Non-FMLA leave, Military Leave)	• 18 months
	• Termination (voluntary or involuntary)	• 18 months
	• Divorce (spouse and children have their own election rights)	• 36 months
	• Employee becomes Medicare eligible (spouse and dependents are eligible)	• 36 months
	• Death of the subscriber (all surviving dependents)	• 36 months
	• Dependent Max dependent age	• 36 months

USERRA

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended, also grants continuation rights to employees who leave their employment to perform military service. Those members may be eligible to elect to continue their group coverage for themselves and their dependents for up to 24 months.

If properly elected, the USERRA continuation coverage begins on the date when the employee's absence from work for the purpose of performing military service begins. If the member performs military service for fewer than 31 days, they cannot be required to pay more than the regular employee share, if any, for the group coverage. If the member performs military service for 31 or more days, they can be required to pay no more than 102% of the full premium under the plan.

Conversion Policies

After coverage ends as described in the “Ending Coverage” section, or at the end of COBRA or Wisconsin continuation of coverage as described under “Continuation” above, a member may be eligible to purchase an Individual Conversion Policy that Physicians Plus makes available to eligible members.

To obtain the Conversion Policy, the member must be eligible, as determined by Physicians Plus, apply to Physicians Plus and pay the required premiums to Physicians Plus. The member must do this within 30 days of the Policyholder notifying the member of their right to conversion coverage. If the member applies and pays within the 30-day period, the conversion Policy will cover the member as of the date coverage under the group Policy ends. Please contact Member Services for more information.

Medicare and Retirees

Members can become eligible for Medicare for various reasons which include age, disability or illness, such as end stage renal disease (ESRD). Medicare determines eligibility. Medicare has four parts or types of coverage:

1. Medicare A – Inpatient hospital services
2. Medicare B – Outpatient physician services
3. Medicare C – Advantage or Cost plans
4. Medicare D – Prescription drug coverage

Physicians Plus cannot force any member to enroll in any part of Medicare; however, Medicare may assess a penalty in some instances for late entry. If a member has questions about their Medicare eligibility, they must contact Medicare directly.

Many employers offer coverage for employees that retire or wish to retire before and/or after Medicare eligibility. Physicians Plus must approve a retiree segment if you intend to offer health insurance to those retirees. The following minimums must be in place before Physicians Plus will approve a retiree division:

- Retiree is no longer working;
- No more than 10% of the population can be retirees;
- Contribution is equal to or exceeds 50% of the single rate;
- Minimum age is 55; and
- Maximum age is 65.

Coordinating benefits with Medicare is an essential piece of retiree coverage. Please consider the following tables and Coordination of Benefit rules when considering retiree coverage for your employees.

Employee is Working

Medicare Eligibility Summary for an Employee who is Working			
Number of total Employees	**Enrollment in Medicare A & B**	**Primary Carrier**	**Secondary Carrier**
2–19	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
2–19 & Medicare Disabled	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
20–99	Not Mandatory. May defer for employee and/or dependents.	Physicians Plus	Medicare
20–99 Medicare Disabled	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
100 or More	Not Mandatory. May defer for employee and/or dependents regardless of age or Medicare disability.	Physicians Plus	Medicare

Employee is Not Working

Medicare Eligibility Summary for an Employee who is Not Working (Retired, on Long Term Disability or Continuation)			
Number of total Employees	**Enrollment in Medicare A & B**	**Primary Carrier**	**Secondary Carrier**
2–19	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
2–19 & Medicare Disabled	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
20–99	Not Mandatory. May defer for employee and/or dependents.	Medicare	Physicians Plus
20–99 Medicare Disabled	Mandatory for employee and/or dependents.	Medicare	Physicians Plus
100 or More	Not Mandatory. May defer for employee and/or dependents regardless of age or Medicare disability.	Medicare	Physicians Plus

NOTE: Group size is determined by the average number of total employees on the payroll record for the prior IRS calendar year. If more than one business is commonly owned, all owned entities are combined. This guideline does not reflect all the possible criteria affecting the primary payer rules. For details please contact the Social Security Administration.

V. Appeals and Grievances

Physicians Plus' resolution processes encompass all levels of appeal including, but not limited to, complaints, grievances and independent review.

Wisconsin requirements for benefit appeals and independent review currently conflict with the requirements of the federal Patient Protection and Affordable Care Act. Our appeals and independent review process may change if the Wisconsin and federal laws are reconciled or otherwise amended. We will notify you in the event of any such changes.

Complaints

Situations might occasionally arise when a member questions or is unhappy with some aspect of the service received through Physicians Plus. Since most questions about benefits and plan operations are resolved on an informal basis, we encourage members to contact the appropriate provider or Member Services. A member's verbal complaint will be documented and investigated. If the complaint is not resolved to the member's satisfaction, the member (or an authorized representative) may file a grievance with Physicians Plus.

Grievances

A Grievance defined as any dissatisfaction with an Adverse Benefit Determination or services provided by, or claims practices of, Physicians Plus that is expressed in writing to Physicians Plus by or on behalf of a member. Members should submit grievances in writing, along with any pertinent documentation, to:

Physicians Plus Insurance Corporation
Attn: Grievance Administrator
2650 Novation Parkway
Madison, WI 53713

Except for an "Expedited Grievance" (defined below), Physicians Plus will acknowledge receipt of a grievance within five business days. We will notify the member in writing of the time and place when the grievance will be heard by the Grievance Committee (which will be at least seven days after the date of our notification to the member).

Except for an expedited grievance, members (or an authorized representative) have the right to participate in, and provide testimony at, their grievance hearing or attend by teleconference. Members also have the right to submit written comments, documents, records and other information relating to their grievance. Upon request, we will provide a member with reasonable access to, and copies of, all documents, records and other information relevant to a grievance. We conduct our grievance process in accordance with the requirements of the federal Patient Protection and Affordable Care Act, as amended, 45 CFR 147.136, and Wisconsin law.

Typically within 30 days of our receipt of a grievance, Physicians Plus will notify the member in writing of the decision made by the Grievance Committee. In some situations Physicians Plus may need additional information and/or time to make a decision. In those cases, Physicians Plus will notify the member that an additional 30 calendar days will be needed to render a decision. The Grievance Committee's decision will inform the member of the disposition of the grievance and of any corrective action taken. If a person is

acting as an authorized representative in the grievance process, Physicians Plus may require written evidence of the representative's authority to act on a member's behalf.

Expedited Grievances

If a member has an "expedited grievance," Physicians Plus will resolve that grievance as soon as possible, taking into account the member's medical exigencies, but not later than 72 hours after Physicians Plus' receipt of the grievance. An "expedited grievance" means a grievance where any of the following applies, as determined by the member's attending provider:

1. The duration of the standard grievance process could seriously jeopardize life or health or ability to regain maximum function; or
2. The member is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

Members are encouraged to provide or have their provider submit all relevant documentation supporting their case. Members who fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Policy will be notified of that fact within 24 hours of the request for expedited grievance and allowed at least 48 hours to provide us the necessary information.

An expedited grievance may be requested in writing or verbally by contacting the Physicians Plus Appeals Administrator or Member Services at (608) 282-8900 or (800) 545-5015. The request should be clearly identified as an "expedited grievance."

Independent Review

What is an independent review? The independent review process gives a member the opportunity to have appropriate medical professionals, who have no connection to Physicians Plus, review an Adverse Benefit Determination that is based on: (a) a medical judgment (including medical necessity, appropriateness, health care setting, or level of care, effectiveness of a covered benefit or that the treatment is experimental), as determined by the independent reviewer; (b) a denial of a request for services from an out-of-network provider when the member believes that the clinical expertise of the out-of-network provider is medically necessary; (c) our denial of coverage based on a preexisting condition exclusion; or (d) our rescission of coverage (whether the rescission has any effect on any particular benefit at that time). For multiple family member grievances, each member must meet the criteria. The treatment or services must otherwise be a covered benefit under the Policy.

Members must complete our internal grievance process before requesting independent review, and an independent review must be requested within four (4) months from receipt of the Grievance Committee's decision approving the Adverse Benefit Determination. A member does not need to exhaust the internal grievance process when we do not meet process timelines (except for certain de minimus violations that do not cause, and are not likely to cause, prejudice or harm to the member) or when a member or their authorized representative simultaneously requests an Expedited Grievance and an expedited independent review.

For most cases, the federal IRO review process will apply. The member should submit the IRO request to MAXIMUS Health Services at the following address:

MAXIMUS, Inc.
State Appeals
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534-1302

By Fax: 1-585-425-5296 or 1-888-866-6190

Online at: www.externalappeal.com

Maximus will assign the dispute to a reviewer who is an expert in the treatment of the medical condition/situation. The IRO has the authority to determine whether Physicians Plus should cover the treatment and/or services. The IRO's decision is final and binding on the member and Physicians Plus for the Adverse Benefit Determination, except to the extent other remedies are available under Wisconsin or federal law and except that the IRO's decision shall not preclude us from making payment on the claim or otherwise providing benefits at any time.

Adverse Benefit Determination

A denial, reduction, termination of or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a person's eligibility for coverage under the Policy, and including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or not medically necessary or appropriate. Adverse benefit determination includes any of the following:

(a) Our determination that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the Policy's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminate;
(b) Any rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at that time;
(c) Our denial of a request for a referral for services from an out-of-network provider when the member requests health care services from the out-of-network provider because the clinical expertise of the out-of-network provider may be medically necessary for treatment of the member's medical condition and that expertise is not available from any in-network provider;
(d) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment in whole or in part, for a benefit; and
(e) Any decision to deny coverage in an initial eligibility determination.

Experimental Treatment Determination means a determination by or on behalf of Physicians Plus to which all of the following criteria apply:

1. A proposed treatment has been reviewed;
2. Based on the information provided, the proposed treatment is determined to be experimental according to the terms of the Policy;
3. Based on the information provided, we denied the proposed treatment or payment for the proposed treatment; and
4. The denial of the proposed treatment completed the Physicians Plus grievance process, except if the criteria for an expedited review are satisfied and the member simultaneously requests an expedited grievance and independent review.

Copies these processes are available at www.pplusic.com/members/member-materials or upon request from Member Services.

Office of the Commissioner of Insurance

A member may resolve their concerns through the previously outlined appeals and grievance processes. They may also contact the Office of the Commissioner of Insurance, a state agency that enforces Wisconsin's insurance laws, and file a complaint. Contact the Office of the Commissioner of Insurance at:

Office of the Commissioner of Insurance
Complaints Department
125 S Webster St
P.O. Box 7873
Madison, WI 53707-7873

Request a complaint form at (608) 266-0103, (800) 236-8517 or oci.wi.gov.

Employee Retirement Income Security Act (ERISA)

ERISA does not apply to State, ETF or Non-Group plans including Medicare Supplement policies. A member may also have a right to bring a civil action under ERISA 502(a) if a timely appeal is filed and the request for coverage or benefits is denied in the appeal process. The appeals must be filed with us no more than 180 days from the date of our initial denial. Please contact your employer for more information on your rights under ERISA.

Thanks Again for Choosing Physicians Plus.

When you select a health plan, you're making an important decision for your extended family … your employees. We are privileged to serve you, and we thank you for trusting Physicians Plus to manage your investment in health care. We promise to deliver the area's broadest provider network, a variety of plan designs to provide you with flexibility and a caring, professional staff that will both support your account and help guide your employees whenever they have concerns or questions, large or small.

We Look Forward to Being Your Partner for Years to Come.

Physicians Plus