WISCONSIN HMO REGULATORY REQUIREMENTS

THESE WISCONSIN HMO REGULATORY REQUIREMENTS (these "HMO Regulatory Requirements") supplement and are made part of the Provider Participation Agreement ("Agreement") between Medica Self-Insured d/b/a SelectCare ("SelectCare") and the Provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

These HMO Regulatory Requirements apply to Payers' products or benefit plans issued under the State of Wisconsin BadgerCare Plus and Medicaid SSI programs (collectively, the "State Medicaid Program") as governed by the State's designated regulatory agencies. In the event of a conflict or inconsistency between these HMO Regulatory Requirements and any term or condition contained in the Agreement, these HMO Regulatory Requirements will control except with regard to: (i) benefit plans outside the scope of these HMO Regulatory Requirements; or (ii) requirements under the State Medicaid Program that may govern.

In the event SelectCare is required to amend or supplement these HMO Regulatory Requirements, as required by the State and requested by the Payer, Provider agrees that SelectCare will be permitted to unilaterally initiate such additions, deletions or modifications, to be effective immediately unless written notice of such amendment is required under law.

SECTION 2
DEFINITIONS

Unless otherwise defined in these HMO Regulatory Requirements, all capitalized terms contained in these HMO Regulatory Requirements will be as defined in the Agreement. For purposes of the State Medicaid Program and these HMO Regulatory Requirements, the following terms will have the meanings set forth below; provided, however, in the event any definition set forth in these HMO Regulatory Requirements or the Agreement is inconsistent with any definitions under the State Medicaid Program, the definitions will have the meaning set forth under the State Medicaid Program.

2.1 **Agreement:** An executed contract between SelectCare and Provider for the provision of Covered Services to persons enrolled in the State Medicaid Program.

2.2 **Covered Person:** An individual who is currently enrolled with Payer for the provision of Covered Services under the State Medicaid Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.3 **Covered Services**: A health care service or product for which a Covered Person is enrolled to receive coverage under the State Medicaid Contract.

2.4 **Provider**: A hospital, ancillary provider, physician group, or individual physician who has entered into an Agreement.

2.5 **State:** The State of Wisconsin or its designated regulatory agencies.

2.6 **State Medicaid Contract:** Payer's contract(s) with the Wisconsin Department of Health and Family Services for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the BadgerCare Plus and/or Medicaid SSI programs (collectively, the "State Medicaid Program").

SECTION 3
HMO REQUIREMENTS

3.1. **Provider Disclosure.** Nothing in the Agreement will be construed to limit Provider's ability to disclose information, to or on behalf of a Covered Person, about the Covered Person's medical condition. Provider may discuss, with or on behalf of a Covered Person, all treatment options and any other information that Provider determines to be in the best interest of the Covered Person and within the scope of Provider's professional license. Neither SelectCare nor Payer may penalize Provider, nor may SelectCare terminate the Agreement because Provider makes referrals to other providers that participate in SelectCare's network or discusses medically necessary or appropriate care with or on behalf of a Covered Person. SelectCare and Payer may not retaliate against Provider for advising a Covered Person of treatment options that are not covered benefits under the Covered Person's benefit plan with Payer.

3.2. **Acknowledgment of Receipt of Notice and Agreement Not to Elect Exemption from Wis. Stat. Section 609.91.** Provider acknowledges receipt of the Notice, in the form attached to these HMO Regulatory Requirements as Exhibit A, required by Wis. Stat., Section 609.94(1). Provider agrees that Provider will not exercise the right under Wis. Stat., Section 609.92 to elect to be exempt from Wis. Stat., Section 609.91(1)(b) for the purpose of recovering health care costs arising from health care furnished by Provider. Provider acknowledges that this agreement not to exercise this right will mean that Provider will remain subject to the restrictions on recovery of health care costs found in Wis. Stat., Section 609.91. In the event that Provider is not subject to the restrictions on recovery of health care costs found at Wis. Stat., Section 609.91(1)(a), (am), or (b), Provider agrees to elect to be subject to said restrictions pursuant to Wis. Stat., Section 609.925 and any applicable regulations, and will promptly take such action as is necessary to implement such election.

3.3. **Continued Provision of Covered Services after Termination.** In the event the Agreement is terminated by Provider for any reason or in the event the Agreement is terminated by SelectCare for any reason other than (a) the Provider no longer practices in SelectCare's geographic service area or (b) misconduct on the part of the Provider, Provider will continue to provide Covered Services for the following periods:

(a) Covered Person Care. If a Covered Person is receiving care from Provider under a prescribed treatment plan and Provider is not a primary care physician, Provider is obligated to continue the provision of Covered Services to that Covered Person until (a)

the completion of the treatment; or (b) a period of ninety (90) days after the effective date of Provider's termination, whichever is shorter, except that the continuation of Covered Services is not required to extend beyond (i) the end of the current plan year, for a Covered Person who has coverage under a benefit plan that has no open enrollment period; or (ii) the end of the plan year for which it was represented that Provider was, or would be, a provider that participates in SelectCare's network for a Covered Person with an open enrollment period. Provider will accept and Payer will pay the amounts established by the Agreement for Covered Services rendered according to this section after termination of the Agreement.

(b) Maternity Care. If a Covered Person is receiving maternity care from Provider and the Covered Person is in her second or third trimester of pregnancy, Provider is obligated to continue the provision of Covered Services to that Covered Person until the completion of the postpartum care. Provider will accept and Payer will pay the amounts established by the Agreement for Covered Services rendered after termination of the Agreement.

(c) Primary Care Physician. If Provider is a primary care physician, Provider is obligated to continue the provision of Covered Services until the end of the current plan year for a Covered Person with no open enrollment period; or until the end of the plan year for which it was represented that Provider was, or would be, a provider that participates in SelectCare's network for a Covered Person with an open enrollment period. Provider will accept and Payer will pay the amounts established by the Agreement for Covered Services rendered after termination of the Agreement.

Additionally, in the event Provider terminates the Agreement for any reason, Provider will, within thirty (30) days prior to the termination or fifteen (15) days following SelectCare's receipt of the termination notice, whichever is later, post a notification of such termination in Provider's office. This notice requirement applies only if Provider is a physician specialist and a referral is not required.

3.4 **Grievances.** Provider must identify complaints and grievances in a timely manner and forward these complaints and grievances to SelectCare and Payer in a timely manner.

EXHIBIT A TO THE WISCONSIN HMO
REGULATORY REQUIREMENTS APPENDIX

NOTICE REQUIRED BY WISCONSIN STATUTE 609.94

NOTICE

THIS NOTICE DESCRIBES HOLD-HARMLESS
PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE
AGAINST HMO ENROLLEES FOR PAYMENT FOR SERVICES.

Section 609.94, Wis. Stat., requires each health maintenance organization insurer (HMO) to provide a summary notice to all of its participating providers of the statutory limitations and requirements in Sections 609.91 to 609.935, and Section 609.97(1).

SUMMARY

Under Wisconsin law, a health care provider may not hold HMO enrollees or policyholders ("enrollees") liable for costs covered under an HMO policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the hold-harmless statutes only if the provider voluntarily "opts-in." An HMO may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

HOLD HARMLESS

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not affect the liability of an enrollee for any deductibles or copayments, or for the premiums owed under the policy, or certificate issued by the HMO.

A. MANDATORY FOR HOLD HARMLESS

An enrollee of an HMO is not liable to a health care provider for health care costs that are covered under a policy issued by that HMO if any of the following are met:

1. Care is provided by a provider who is an affiliate of the HMO, owns at least 5% of the voting securities of the HMO, is directly or indirectly involved with the HMO through direct or indirect selection of or representation by one or more board members, or is an Individual Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO board members who directly or indirectly represent one or more IPAs or affiliates of IPAs; or,

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.; or

3. To the extent the charge exceeds the amount the HMO has contractually agreed to pay the provider for that health care service; or

4. The care is provided to an enrolled medical assistant recipient under a Department of Health and Social Services prepaid health care policy.

5. The care is required to be provided under the requirements of Wis. Admin. Code, Ins. 9.35.

B. "OPT-OUT" HOLD HARMLESS

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care meets any of the following:

1. Provided by a hospital or an IPA; or

2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO or are provided by a provider selected by the HMO; or

3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA which has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless (See Exemptions and Elections; #4).

C. "OPT-IN" HOLD HARMLESS

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with the OCI

stating that the provider elects to be subject with respect to any specific HMO. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

CONDITIONS NOT AFFECTING IMMUNITY

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute);

2. A breach of or default on any agreement by the HMO, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable;

3. The insolvency of the HMO or any person contracting with the HMO, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO or other persons which would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless;

4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable;

5. Failure by the HMO to provide notice to providers of the statutory hold-harmless provisions; or

6. Any other condition or agreement existing at any time.

EXEMPTIONS AND ELECTIONS

Hospitals, IPAs, and providers of physician services who may "opt-out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO, the provider must within thirty (30) days after entering into that contract provide a notice to the OCI of the provider's election to be exempt from the statutory hold harmless and recovery limitations for care under the contract.

2. If the hospital, IPA, or other provider does not have a contract with an HMO, the provider must notify OCI that it intends to be exempt with respect to a specific HMO and must provide that notice at least ninety (90) days in advance.

3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.

4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions of the failure of the clinic to elect to be exempt applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.

5. The statutory hold-harmless "opt-out" provision applies to physician services only if the services are provided under a contract with the HMO or if the physician is a selected provider for the HMO, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless "opt-out" provisions.

NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control or the provider, HMO, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written and received at the Office's current address:

Office of the Commissioner of Insurance
123 West Washington Avenue
P.O. Box 7873
Madison, WI 53707

HMO CAPITAL AND SECURITY SURPLUS

Each HMO is required to meet minimum capital and surplus standards ("compulsory surplus requirements"). These standards are higher if the HMO has fewer than 90% of its liabilities covered by the statutory hold harmless. Specifically, the compulsory surplus requirements will be at least the greater of $750,000 or 6% of the premiums earned by the HMO in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO in the last 12 months if its covered liabilities are more than 90%.

In addition to capital and surplus, an HMO must also maintain a security surplus in the amount set by the Commission of Insurance.

FINANCIAL INFORMATION

An HMO is required to file financial statements with the OCI. You may request financial statements from the HMO. The OCI also maintains files of HMO financial statements that can be inspected by the public.