

Certificate of Coverage - POS

WPS Health Plan, Inc. d/b/a Arise Health Plan
421 Lawrence Drive
De Pere, WI 54115
(920) 490-6900
1-888-711-1444

IMPORTANT NOTICE: The policy is a point of service (“POS”) policy. The policy provides benefits for covered health care services you receive from participating providers and non-participating providers

This certificate is not the contract of insurance. It is merely evidence of insurance provided under the group medical insurance policy (hereinafter called “group policy” or “policy”) issued by Arise Health Plan to the group policyholder (hereinafter called “group policyholder” or “policyholder”). This certificate describes the essential features of such insurance. This certificate replaces and supersedes any certificates and endorsements we issued to you prior to the effective date of this certificate.

The policy includes a Schedule of Benefits. It may also include one or several endorsements. **Please read all of these documents carefully so you know and understand your coverage.**

Unless otherwise stated, we will not pay for any health care services under the policy until you have paid certain out-of-pocket amounts. These out-of-pocket amounts are called deductibles. Please see the Schedule of Benefits to determine your annual deductible amounts. Other cost-sharing aspects of the policy, such as coinsurance and co-pays, are discussed in section “PAYMENT OF BENEFITS.” Please review this section carefully so that you understand what your share of each health care expense will be under the policy.

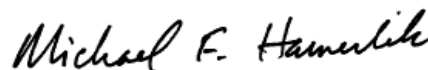
The insurance described in this certificate limits charges for covered expenses to the amounts we determine as being the maximum allowable fee. This amount may be less than the amount billed. Please see the definition of “maximum allowable fee” in section “DEFINITIONS.” If you would like more information, please contact our Customer Service Department by calling the telephone number shown on your Arise Health Plan identification card.

This certificate does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your agent or the Federally-Facilitated Marketplace, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

In performing its obligations under the policy, Arise Health Plan is acting only as a health insurer with respect to the policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), or any other federal or state law.

The group policy is issued by Arise Health Plan and delivered to the policyholder in Wisconsin. All terms, conditions, and provisions of the group policy, including, but not limited to, all exclusions and coverage limitations contained in the group policy, are governed by the laws of Wisconsin. All benefits are provided in accordance with the terms, conditions, and provisions of the group policy, any endorsements attached to this certificate, your completed application for this insurance, and applicable laws and regulations.

WPS HEALTH PLAN, INC. D/B/A ARISE HEALTH PLAN



Michael F. Hamerlik
President and Chief Executive Officer

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GENERAL INFORMATION

How Group Coverage Works

Arise Health Plan has issued a group policy to your employer, who we call the “policyholder.” The group policy (the “policy”) forms a contract between us and your employer under which we provide health insurance coverage for certain employees. This certificate describes the health insurance benefits you are entitled to receive. We provide the benefits described in this certificate under the terms, conditions and provisions of the group policy.

Any employee to whom we issue this certificate is a “covered employee.” Any person that is eligible and approved to receive health insurance coverage under this certificate, including the covered employee, is a “covered person.” For example, if a covered employee is issued limited family or family coverage under the group policy, the covered employee and his/her eligible dependents that we have approved for coverage are all covered persons. Subject to the group policy, each covered person is insured for the coverage described in this certificate. Please see subsection “Entire Contract.”

General Description of Coverage

Coverage is subject to all terms, conditions and provisions of the policy. This certificate replaces and supersedes any certificates we issued to the policyholder before the effective date of the policy and any written or oral representations that we or our representatives made.

This certificate describes the two benefit levels. One benefit level applies when you receive covered health care services provided by a participating provider. The other benefit level applies when you receive covered health care services provided by a non-participating provider.

How to Use This Certificate

This certificate, including its Schedule of Benefits and all endorsements, should be read carefully and completely by you. The provisions of this certificate are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a clear or full understanding of your coverage under the policy.

Each term used in this certificate has a special meaning. These terms are defined for you in section “DEFINITIONS.” By understanding these definitions, you will have a better understanding of your coverage under the policy.

Your Choice of Health Care Providers Affects Your Benefits

Participating providers are health care providers who are part of our network as shown on your Arise Health Plan identification card. See section “DEFINITIONS” for more information.

If you use a participating provider, covered charges will be payable under this policy based on the provider’s agreement with us, subject to any deductible, coinsurance, and copayment provisions. If there is a difference between the amount we pay and the amount the participating provider bills, you are not responsible for that amount.

Non-participating providers are health care providers who have not agreed to participate in the health care network shown on your Arise Health Plan identification card.

If you use a non-participating provider, covered charges will be payable under this policy up to the maximum out-of-network allowable fee as defined in section “DEFINITIONS.” If there is a difference

between the amount that we pay and the amount that the non-participating provider bills, you are responsible for that amount.

Changes to the Policy

We reserve the right to change, interpret, modify, remove or add benefits, or terminate the policy, at our sole discretion, subject to the notice requirements stated in subsection "Waiver and Change." When a change occurs, a new certificate or endorsement for this certificate will be made available to each covered employee online. That means your coverage under the policy will change to the extent described in the new certificate or endorsement, as of the effective date of that new certificate or endorsement. No person or entity other than Arise Health Plan has the authority to make oral changes or amendments to the policy.

Covered Expenses

The policy only provides benefits for certain health care services. Just because a physician has performed or prescribed a health care service does not mean that it will be covered under the policy. Likewise, just because a health care service is the only available health care service for your illness or injury does not mean that the health care service will be covered under the policy. We have the sole and exclusive right to interpret and apply the policy's provisions and to make factual determinations. This means, for example, we also have the sole and exclusive right to determine whether benefits are payable for a particular health care service.

In certain circumstances for purposes of overall cost savings or efficiency, we may at our sole discretion, pay benefits for health care services: (1) at the participating provider level of benefits for a health care service provided by a non-participating provider; or (2) that are not covered under the policy, to the limited extent provided in subsection "Alternate Care." The fact that we provide such coverage in one case shall not require us to do so in any other case, regardless of any similarities between the two.

We may, at our sole discretion, arrange for other persons or entities to provide administrative services in regard to the policy, including claims processing and utilization review management services. We may also, at our sole discretion, authorize other persons or entities to exercise discretionary authority with regard to the policy. The identity of these persons or entities and the nature of the services they provide to us may be changed at any time without prior notice to or approval from you. By accepting this certificate, you agree to cooperate fully with those persons or entities in the performance of their responsibilities.

OBTAINING SERVICES

Choosing a Participating Physician

Each covered person must choose a participating primary care physician (PCP) and notify us of his/her selection. A primary care physician (PCP) is also referred to as a primary care practitioner. You may choose any PCP who participates in our network and who is available to accept you. For children, a covered employee may designate a participating pediatrician as the child's PCP.

For information on how to select a PCP, contact our Customer Service Department at (920) 490-6900 (local) or 1-888-711-1444 (toll-free). For a complete list of primary care physicians in your network, please visit the "Find A Doctor" webpage at www.WeCareForWisconsin.com or contact Customer Service. Please note that if you do not choose a PCP, we will designate one for you.

Although you may change your PCP at any time, we encourage you to establish a relationship with one PCP. You must notify us each time you select a different PCP.

Participating Provider Benefits

Except as stated in the policy, participating provider benefits are payable only when you receive health care services from:

1. A participating provider;
2. A non-participating provider if you have submitted and we have approved a prior authorization to seek health care services from that provider. We will only approve health care services provided by a non-participating provider when those health care services are not available from a participating provider and necessary to treat your illness or injury;
3. A radiologist, pathologist, or anesthesiologist who is on staff at a participating hospital or ordered by a participating provider; or
4. A radiologist, pathologist, or anesthesiologist who is on staff at a non-participating hospital if you have submitted and we have approved a prior authorization to seek health care services at a non-participating hospital.

Participating providers are not permitted to bill you for any charges for covered services above the maximum allowable fee. Health care services you receive from participating providers are only subject to your deductible, copayments, and coinsurance. See section "PAYMENT OF BENEFITS" for additional information about cost-sharing under the policy.

Non-Participating Provider Benefits

If you receive health care services from a non-participating provider, benefits provided are limited to the maximum out-of-network allowable fee and you will be responsible for paying any difference between that amount and the charge billed. For example, if the non-participating provider's charge is \$100 and the maximum out-of-network allowable fee is \$70, you will be responsible for paying the remaining balance of \$30.

Prior Authorization

You are required to obtain prior authorization before you visit certain health care providers or receive certain health care services, such as pain management, spinal surgery, new technologies (may be considered experimental/investigational/unproven), non-emergency ambulance, high-cost durable medical equipment, high-technology imaging, or procedures that could potentially be considered cosmetic. You can find a current list of health care providers and health care services for which prior authorization is required on our website at www.WeCareForWisconsin.com. Please refer to this website often, as it may change from time to time at our sole discretion.

1. How to Request a Prior Authorization.

Your health care provider can start the prior authorization process by calling our Customer Service Department at (920) 490-6900 (local) or 1-888-711-1444 (toll-free) or by downloading a printable Prior Authorization Form from our website as www.WeCareForWisconsin.com. After the health care provider faxes or mails the prior authorization request, we suggest that you call Customer Service to verify that it has been received. Please allow up to 15 business days for the review process.

Although your health care provider should initiate the prior authorization process, it is **your** responsibility to ensure that:

- a. the prior authorization request form is obtained and completed in consultation with your health care provider;

- b. the prior authorization request is submitted to and received by us;
- c. the prior authorization request is approved by us before you obtain the applicable health care services.

After we review your request, we will send a written response to you and/or the health care provider who submitted the request. Our benefit determination(s) will be based upon the information available to us at the time we receive your request.

If we approve your request, our prior authorization will only be valid for: (a) the covered person for whom the prior authorization was made; (b) the health care services specified in the prior authorization and approved by us; and (c) the specific period of time and service location approved by us.

A standing authorization is subject to the same prior authorization requirements stated above. If we approve a standing authorization, you may request that the designated specialist provide primary care services, as long as your health care provider agrees.

2. Consequences for Failing to Obtain a Prior Authorization.

Failure to comply with the prior authorization process outlined in this subsection will initially result in no benefits being paid under the policy. If, however, a health care service is denied solely because you did not obtain our prior authorization, you can request that we review and reconsider the denial of benefits by following the Claim Appeal Procedure outlined in the policy. If you prove to us that the health care service would have been covered under your policy if you had followed the prior authorization process, we will overturn the prior authorization penalty and reprocess the affected claim(s) in accordance with your standard benefits.

3. Health Care Services That Do Not Require a Prior Authorization.

You do not need a prior authorization from us or any other person (including your PCP) to obtain the following:

- a. obstetrical or gynecological (OB/GYN) care from a participating provider who specializes in obstetrics or gynecology. The participating provider, however, may be required to comply with certain procedures, including obtaining a prior authorization for certain health care services, following a pre-approved treatment plan, or making referrals. For a list of participating OB/GYN providers, contact our Customer Service Department.
- b. emergency care or urgent care at an emergency or urgent care facility.
- c. covered radiologist, pathologist and anesthesiologist services at a participating facility.

Coding Errors

In some cases we may determine that the health care provider or its agent didn't use the appropriate billing code to identify the health care service provided to you. We reserve the right to recodify and assign a different billing code to any health care service that we've determined was not billed using the appropriate billing code.

OUR UTILIZATION MANAGEMENT PROGRAM

Utilization management (UM) is the evaluation of a health care service's medical necessity. Our UM program is designed to ensure that you are receiving high-quality medical care that is both appropriate and cost effective. You will receive benefits under the policy only when health care services are determined to be medically necessary. The fact that a health care provider has prescribed, ordered, recommended, or approved a health care service or has informed you of its availability does not, in itself, make the service medically necessary. We will make the final determination of whether any service constitutes medically necessary care as defined by the policy.

CONTINUITY OF CARE

Under certain circumstances, if a health care provider leaves our network, you may, under the following circumstances, continue to receive care from that physician at the participating provider benefit level for a designated period of time:

1. Primary Care Physician.

We will continue to cover health care services provided by a participating primary care physician until the end of the plan year for which we represented that the health care provider was, or would be, a participating provider.

2. Specialty Care Physician.

If you are undergoing a course of treatment with a specialty physician, we will continue to cover health care services from that health care provider for the following period of time, whichever is shorter: (a) for the remainder of the course of treatment; or (b) for 90 days after the health care provider's participation in our network terminates.

3. Maternity Services.

We will continue to cover services for a female covered person who is in her second or third trimester of pregnancy until the completion of postpartum care for her and her infant.

The provisions above do not apply when: (1) the health care provider no longer practices within the area in which we are authorized to do business; or (2) the health care provider's participation with us is terminated because of the provider's misconduct.

DEFINITIONS

In this certificate, the following terms shall mean:

Activities of Daily Living (ADL): the following, whether performed with or without assistance:

1. Bathing which is the cleansing of the body in either a tub or shower or by sponge bath;
2. Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;

3. Toileting which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
4. Mobility, which is to move from one place to another, with or without assistance of equipment;
5. Eating, which is getting nourishment into the body by any means other than intravenous; and
6. Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

Ambulance Services: ground and air transportation: (1) to the nearest hospital where emergency health care services can be provided; (2) provided by a licensed ambulance service using its licensed and/or certified vehicle, helicopter, or plane which is designed, equipped, and used to transport you when you are sick or injured; and (3) which is staffed by emergency medical technicians, paramedics, or other certified medical professionals.

Behavioral Health Services: health care services for the treatment of alcoholism, drug abuse and nervous or mental disorders.

Benefits: your right to payment for covered health care services that are available under the policy. Your right to benefits is subject to the terms, conditions, limitations and exclusions of the policy, including this certificate, the Schedule of Benefits and any attached endorsements.

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

Calendar Year: the period of time that starts with your applicable effective date of coverage shown in our records, as determined by us, and ends on December 31st of such year. Each following calendar year shall start on January 1st of that year and end on December 31st of that same year.

Certificate: the certificate of coverage that is issued to covered employees summarizing the terms, conditions, and limitations of their group health care coverage.

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

Charge: an amount billed by a health care provider for a health care service. Charges are incurred on the date you receive the health care service.

Child/Children: any of the following:

1. A natural, biological child of a covered employee.
2. A step-child of a covered employee.
3. A legally adopted child or a child placed for adoption with the covered employee.
4. A child under the covered employee's (or his/her spouse's) legal guardianship as ordered by a court. To be initially eligible for coverage, the child must be under the age of 18 and you must have sole and permanent guardianship of both the child and his/her estate.
5. A child who is considered an alternate recipient under a qualified medical child support order.
6. The child of a covered employee's domestic partner provided that:
 - a. the domestic partner is enrolled as a covered person under the policy; and

- b. the domestic partner is the biological parent or has a court-appointed legal relationship with the child (i.e. through adoption).

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

Confinement/Confined: the period starting with your admission on an inpatient basis to a hospital or other licensed health care facility for treatment of an illness or injury. Confinement ends with your discharge from the same hospital or other facility.

Convenient Care Clinic: a medical clinic that: (1) is located in a retail store, supermarket, pharmacy or other non-traditional, convenient, and accessible setting; and (2) provides covered health care services performed by nurse practitioners, physician assistants, or physicians acting within the scope of their respective licenses.

Copayment: the portion of the charge for a covered expense that you are required to pay to the health care provider for a certain health care service covered under the policy. Copayments are a specific dollar amount. Please note that for covered health care services, you are responsible for paying the lesser of the following: (1) the applicable copayment; or (2) the covered expense.

Cosmetic Treatment: any health care service used solely to: (1) change or improve your physical appearance or self-esteem; or (2) treat a condition that causes no functional impairment or threat to your health.

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

Covered Employee: an eligible employee who has properly enrolled and been approved by us for coverage under the policy.

Covered Expenses: any charge, or any portion thereof, that is eligible for full or partial payment under the policy.

Covered Person: a covered employee and/or his/her covered dependent(s).

Custodial Care: health care services given to you if: (1) you do not require the technical skills of a registered nurse at all times; (2) you need assistance to perform one or more activities of daily living; and (3) the health care services you require are not likely to improve your physical and/or mental condition. Health care services may still be considered custodial care, as determined by us, even if: (1) you are under the care of a physician; (2) the physician prescribes health care services to support and maintain your physical and/or mental condition; or (3) health care services are being directly provided to you by a registered nurse or licensed practical nurse, a physical, occupational, or speech therapist, or a physician.

Deductible: the amount that you are required to pay for covered expenses in a calendar year before benefits are payable under the policy.

Dependent: an individual who falls into one or more of the five categories below and who is not on active military duty for longer than 30 days:

1. A covered employee's legal spouse.
2. A covered employee's child, under the age of 26.
3. A covered employee's child who is a full-time student returning from military duty as defined in the policy.
4. A covered employee's child over age 26 if all of the following criteria are met:

- a. the child's coverage under the policy began before he/she reached age 26;
 - b. the child is incapable of self-sustaining employment because of intellectual disability or physical handicap;
 - c. the child is chiefly dependent upon the covered employee for support and maintenance;
 - d. the child's incapacity existed before he/she reached age 26; and
 - e. the covered employee's family coverage remains in force under the policy.
5. A natural child of a covered employee's child if the covered employee's child is under 18 years old.
6. If shown in the policyholder's current application for coverage as being applicable, a covered employee's domestic partner, provided all of the following conditions are met:
- a. the covered employee and his/her partner are in a committed relationship (relationship of mutual support, caring and commitment and intend to remain in such a relationship in the immediate future);
 - b. each partner is 18 years of age or older;
 - c. neither partner is married or legally separated in marriage, or has been a party to an action or proceeding for divorce or annulment within six months of registration, or, if one has been married, at least six months have lapsed since the date of the judgment terminating the marriage;
 - d. each partner is competent to contract;
 - e. neither partner is currently registered in another domestic partnership, and if either party has been in such a registered relationship, at least six months have lapsed since the effective date of termination of that registered relationship;
 - f. there are no blood ties between the covered employee and his/her partner closer than that permitted for marriage or for domestic partner registration;
 - g. the covered employee and his/her partner live together (i.e., occupy the same dwelling unit as a single non-profit housekeeping unit and have a relationship which is of permanent and domestic character);
 - h. the relationship of the covered employee and his/her partner is not merely temporary, social, political, commercial or economic in nature (i.e., there must be mutual financial interdependency);
 - i. the covered employee has registered his/her partner as a domestic partner with the policyholder and Arise Health Plan by providing proof that, for at least the six month period immediately preceding the date of registration, the covered employee either:
 - (1) had obtained a domestic partnership certificate from the city, county or state of residence or from any other city, county or state offering the ability to register a domestic partnership; or
 - (2) has any three of the following with respect to the domestic partner:
 - (a) joint lease, mortgage or deed;
 - (b) joint ownership of a vehicle;

- (c) joint ownership of checking account (demand deposit) or credit account;
- (d) designation of the domestic partner as a beneficiary of the covered employee's will;
- (e) designation of the domestic partner as a beneficiary for the covered employee's life insurance or retirement benefits;
- (f) designation of the partner as holding power of attorney for health care; or
- (g) shared household expenses.

Developmental Delay: any disease or condition that interrupts or delays the sequence and rate of normal growth and development in any functional area and is expected to continue for an extended period of time or for a lifetime. Functional areas include, but are not limited to, cognitive development, physical development, communication (including speech and hearing), social/emotional development, and adaptive skills. Developmental delays can occur even in the absence of a documented identifiable precipitating cause or established diagnosis. Developmental delays may or may not be congenital (present from birth).

Durable Medical Equipment: an item that we determine meets all of the following requirements: (1) it can withstand repeated use; (2) it is primarily used to serve a medical purpose with respect to an illness or injury; (3) it is generally not useful to a person in the absence of an illness or injury; (4) it is appropriate for use in your home; (5) it is prescribed by a physician; and (6) it is medically necessary. Durable medical equipment includes, but is not limited to: wheelchairs; oxygen equipment (including oxygen); and hospital-type beds.

Eligible Employee: a person who is either (1) employed by the policyholder on a permanent, full-time basis for the required number of hours per week as shown in the policyholder's current Arise Health Plan application for coverage; or (2) identified by the policyholder as an employee that must be covered pursuant to the Patient Protection and Affordable Care Act.

Emergency Medical Care: health care services to treat your medical emergency.

Emergency Room Visit: a meeting between you and a physician or other health care provider that: (1) occurs at the hospital emergency room or any other facility charge as an extension of the hospital emergency room including urgent care rooms; (2) includes only the charges for the emergency room fee billed by the hospital for use of the hospital emergency room.

Experimental/Investigational/Unproven: as determined by our Corporate Medical Director, any health care service or facility that meets at least one of the following criteria:

1. It is not currently recognized as accepted medical practice;
2. It was not recognized as accepted medical practice at the time the charges were incurred;
3. It has not been approved by the United States Food and Drug Administration upon completion of Phase III clinical investigation;
4. It is being used in a way that is not approved by the United States Food and Drug Administration (FDA) or listed in the FDA-approved labeling (i.e. off-label use except for off-label uses that are accepted medical practice);
5. It has not successfully completed all phases of clinical trials, unless required by law;
6. It is based upon or similar to a treatment protocol used in on-going clinical trials;

7. Prevailing peer-reviewed medical literature in the United States has failed to demonstrate that it is safe and effective for your condition;
8. There is not enough scientific evidence to demonstrate or make a convincing argument that (a) it can measure or alter the sought after changes to your illness or injury or (b) such measurement or alteration will affect your health outcome; or support conclusions concerning the effect of the drug, device, procedure, service or treatment on health outcomes.
9. It is associated with a Category III CPT code developed by the American Medical Association.

The above list is not all-inclusive.

A health care service or facility may be considered experimental/investigational/unproven even if the health care provider has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

The following are covered under the policy as described in subsection "Prescription Legend Drugs": (1) investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended; and (2) drugs which by law require a written prescription used in the treatment of cancer that may not currently have FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis.

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

Family Coverage: coverage that applies to a covered employee and his/her covered dependents. When referred to in this certificate, family coverage also includes limited family coverage.

Full-Time Student: a child in regular full-time attendance at an accredited secondary school, accredited vocational school, accredited technical school, accredited adult education school, accredited college or accredited university. Such school must provide a schedule of scholastic courses and its principal activity must be to provide an academic education. An apprenticeship program is not considered an accredited school, college or university for this purpose. Full-time student status generally requires that the student take 12 or more credits per semester; however, the exact number of credits per semester depends on the manner in which the school defines regular full-time status for its general student body; this may vary if the school has trimesters, quarters, or another type of schedule for its general student body. Proof of enrollment, course load and attendance is required upon our request. Full-time student status includes any regular school vacation period (summer, semester break, etc.).

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

1. The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education; and
2. The child was under the age of 27 when called to federal active duty; and
3. Within 12 months after returning from federal active duty, the child returned to an institution of higher education on a full-time basis, regardless of age.

The adult child must: (1) attend an accredited school for the number of credits, hours, or courses required by the school to be considered a full-time student; or (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in

either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his/her degree. The adult child continues to be a full-time student during periods of vacation or between term periods established by the school.

Functional Impairment: a significant and documented deviation, loss, or loss of use of any body structure or body function that results in a person's inability to regularly perform one or more activity of daily living or an instrumental activity of daily living such as using transportation, shopping or handling finances.

Genetic Testing: examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Geographical Service Area: the region in which Arise Health Plan operates and your plan is available, as determined by us. Please see www.WeCareForWisconsin.com for more information.

Group Policy/Policy: the group medical insurance policy issued by us to the employer known as the group policyholder. In it, we agree to insure certain members of the group policyholder for future health care services covered by the policy through benefit payments, subject to the terms, conditions and provisions of the policy.

Habilitative Services: health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include, but are not limited to, therapy for a child who isn't walking or talking at the expected age. These health care services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Provider: any physician, hospital, pharmacy, clinic, skilled nursing facility, surgical center or other person, institution or other entity licensed by the state in which he/she/it is located to provide health care services.

Health Care Services: diagnosis, treatment, services, procedures, drugs, medicines, devices, or supplies directly provided to you by a health care provider acting within the lawful scope of his/her/its license.

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

High-Technology Imaging: magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), single photon emission computed tomography (SPECT), computed tomography (CT) imaging, and nuclear stress testing for high-end imaging.

Home Care: health care services provided directly to you in your home under a written plan that meets the following criteria: (1) the plan is developed by your attending physician; (2) the plan is approved by your attending physician in writing; (3) the plan is reviewed by your attending physician every two months (or less frequently if your physician believes and we agree that less frequent reviews are enough); and (4) home care is provided or coordinated by a home health agency or certified rehabilitation agency that is licensed by the Wisconsin Department of Health Services or certified by Medicare.

Home Visit: either of the following:

1. For health care services other than behavioral health services, a meeting between you and a physician or other health care provider that: (a) occurs in your home; and (b) involves you receiving medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology or as determined by us); or manipulations by a physician, other than services related to physical therapy.

2. For behavioral health services, a meeting between you and a licensed psychiatrist, a licensed or certified psychologist, or a health care provider licensed to provide nonresidential services that: (a) occurs in your home; and (b) is for the treatment of nervous or mental disorders, alcoholism or drug abuse; and (c) involves you receiving psychotherapy, psychiatric diagnostic interviews, medication management, behavioral counseling, and neuropsychological testing.

Hospice Care: health care services that are: (1) provided to a covered person whose life expectancy, as certified by a physician, is six consecutive months or less; (2) available on an intermittent basis with on-call health care services available on a 24-hour basis; and (3) provided by a licensed hospice care provider approved by us. Hospice care includes services intended primarily to provide pain relief, symptom management, and medical support services. Hospice care may be provided at hospice facilities or in your place of residence.

Hospital: a facility providing 24-hour continuous service to a confined covered person. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons. A professional staff of licensed physicians and surgeons must provide or supervise its services. It must provide general hospital and major surgical facilities and services. A hospital also includes a specialty hospital approved by us and licensed and accepted by the appropriate state or regulatory agency to provide diagnosis and short term treatment for patients who have specified medical conditions. A hospital does not include, as determined by us: (1) a convalescent or extended care facility unit within or affiliated with the hospital; (2) a clinic; (3) a nursing, rest or convalescent home; (4) an extended care facility; (5) a facility operated mainly for care of the aged; (6) a facility operated mainly for treatment of nervous or mental disorders, drug abuse or alcoholism; (7) sub-acute care center; or (8) a health resort, spa or sanitarium.

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

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

Incidental/Inclusive: a procedure or service is incidental/inclusive if it is integral to the performance of another health care service or if it can be performed at the same time as another health care service without adding significant time or effort to the other health care service.

Infertility: the inability or diminished ability to produce offspring including, but not limited to, a couple's failure to achieve pregnancy after at least 12 consecutive months of unprotected sexual intercourse or a woman's repeated failures to carry a pregnancy to fetal viability. Repeated failures to carry a pregnancy to fetal viability means three consecutive documented spontaneous abortions in the first or second trimester. Such inability must be documented by a health care provider.

Infertility or Fertility Treatment: a health care service that is intended to: (1) promote or preserve fertility; or (2) achieve and maintain a condition of pregnancy.

For purposes of this definition, infertility or fertility treatment includes, but is not limited to:

1. Fertility tests and drugs;
2. Tests and exams done to prepare for or follow through with induced conception;
3. Surgical reversal of a sterilized state that was a result of a previous surgery;
4. Sperm enhancement procedures;
5. Direct attempts to cause or maintain pregnancy by any means including, but not limited to:
 - a. hormone therapy or drugs;
 - b. artificial insemination;

- c. in vitro fertilization;
 - d. GIFT or ZIFT;
 - e. embryo transfer; and
 - f. freezing or storage of embryo, eggs, or semen; and
6. Evaluation and treatment of repeated failures to carry a pregnancy to fetal viability when not pregnant.

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

Limited Family Coverage: coverage that applies to: (1) a covered employee and his/her eligible spouse who is a covered dependent; or (2) a covered employee and his/her dependent children who are covered dependents.

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

Maximum Allowable Fee: the maximum amount of reimbursement allowed for a covered health care service. For a covered health care service provided by a participating provider, the maximum allowable fee is the rate negotiated between us and the participating provider. For a covered health care service provided by a non-participating provider, the maximum allowable fee is the maximum out-of-network allowable fee.

Upon written or oral request from you for our maximum allowable fee for a health care service and if you provide us with the appropriate billing code that identifies the health care service (for example, CPT codes, ICD 10 codes or hospital revenue codes) and the health care provider's estimated fee for that health care service, we will provide you with any of the following:

1. A description of our specific methodology, including, but not limited to, the following:
 - a. the source of the data used, such as our claims experience, an expert panel of health care providers, or other sources;
 - b. the frequency of updating such data;
 - c. the geographic area used;
 - d. if applicable, the percentile used by us in determining the maximum allowable fee; and
 - e. any supplemental information used by us in determining the maximum allowable fee.
2. The maximum allowable fee determined by us under our guidelines for a specific health care service provided to you. That may be in the form of a range of payments or maximum payment.

Maximum Out-of-Network Allowable Fee: the benefit limit established by us for a covered health care service provided by a non-participating provider. The benefit limit for a particular health care service is based on a percentage of the published rate allowed for Wisconsin by the Centers for Medicare and Medicaid Services (CMS) for the same or similar health care service. When there is no CMS rate available for the same or similar health care service, the benefit limit is based on an appropriate commercial market fee for the covered health care service, as determined by us.

Medical Emergency: a medical condition that involves acute and abnormal symptoms of such severity (including severe pain) to lead a prudent sensible person who possesses an average knowledge of health and medicine would reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
2. Serious impairment to the person's bodily functions; or
3. Serious dysfunction of one or more of the person's body organs or parts.

Medically Necessary: a health care service or facility that we determine to be:

1. Consistent with and appropriate for the diagnosis or treatment of your illness or injury;
2. Commonly and customarily recognized and generally accepted by the medical profession in the United States as appropriate and standard care for the condition being evaluated or treated;
3. Substantiated by the clinical documentation;
4. The most appropriate and cost effective level of care that can safely be provided to you. Appropriate and cost effective does not necessarily mean the least expensive;
5. Proven to be useful or likely to be successful, yield additional information, or improve clinical outcome; and
6. Not primarily for the convenience or preference of the covered person, his/her family, or any health care provider.

A health care service or facility may not be considered medically necessary even if the health care provider has performed, prescribed, recommended, ordered, or approved the service, or if the service is the only available procedure or treatment for your condition.

Medical Services: health care services recognized by a physician to treat your illness or injury.

Medical Supplies: items that we determine to be: (1) used primarily to treat an illness or injury; (2) generally not useful to a person in the absence of an illness or injury; (3) the most appropriate item that can be safely provided to you and accomplish the desired end result in the most economical manner; and (4) not primarily for the patient's comfort or convenience; and (5) prescribed by a physician.

Miscellaneous Hospital Expenses: regular hospital costs (including take-home drug expenses) that we cover under the policy for treatment of an illness or injury requiring either: (1) inpatient hospitalization; or (2) outpatient health care services at a hospital. For outpatient health care services, miscellaneous hospital expenses include charges for: (1) use of the hospital's emergency room; and (2) emergency medical care provided to you at the hospital. Miscellaneous hospital expenses do not include room and board, nursing services, and ambulance services.

Nervous or Mental Disorders: clinically significant psychological syndromes that: (1) are associated with distress, dysfunction or physical illness; and (2) represent a dysfunctional response to a situation or event that exposes you to an increased risk of pain, suffering, conflict, physical illness or death. Behavior problems, learning disabilities or developmental delays are not nervous or mental disorders.

Non-Participating Provider: a health care provider that has not entered into a written agreement with us to provide covered services to you as of the date upon which the services are provided.

Nurse Practitioner: a person who is licensed as a registered nurse under Chapter 441, Wisconsin Statutes, as amended, or the laws and regulations of another state and who satisfies any of the following:

1. Is certified as a primary care nurse practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates;
2. Holds a master's degree in nursing from an accredited school of nursing;
3. Prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least four months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program; or
4. Has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of 3. above, and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

Obesity: a body mass index (BMI) of 30 or greater. BMI is calculated by dividing your weight in kilograms by the square of your height in meters.

Office Visit: either of the following:

1. For health care services other than behavioral health services, a meeting between you and a physician or other health care provider that: (a) occurs at the provider's office, a medical clinic, convenient care clinic, an ambulatory surgical center, a free-standing urgent care center, skilled nursing facility, or the outpatient department of a hospital, other than a hospital's emergency room; and (b) includes you receiving medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology or as determined by us) or manipulations by a physician, other than services related to physical therapy.
2. For behavioral health services, a meeting between you and a licensed psychiatrist, a licensed or certified psychologist, or a health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse that: (a) occurs in the provider's office, a medical clinic, a free-standing urgent care center, skilled nursing facility, outpatient treatment facility or the outpatient department of a hospital, other than a hospital's emergency room; and (b) involves you receiving psychotherapy, psychiatric diagnostic interviews, medication management, electro-shock therapy, behavioral counseling, or neuropsychological testing.

Oral Surgery: surgical services performed within the oral cavity.

Participating Provider: a health care provider that has entered into a written agreement with us to provide covered services to you as of the date upon which the services are provided. A health care provider's participation status may change from time to time. Please refer to our on-line provider directory or contact us for a listing of participating providers.

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

Physician: a person who:

1. Received one of the following degrees in medicine from an accredited college or university: Doctor of Medicine (M.D.); Doctor of Osteopathy (D.O); Doctor of Dental Surgery (D.D.S); Doctor of Dental Medicine (D.D.M.); Doctor of Surgical Chiropody (D.S.C.); Doctor of Podiatric Medicine (D.P.M.); Doctor of Optometry (O.D.); or Doctor of Chiropractic (D.C.);

2. Is a medical doctor or surgeon licensed by the state in which he/she is located; and
3. Practices medicine within the lawful scope of his/her license.

When we are required by law to cover the health care services of any other licensed medical professional under the policy, a physician also includes such other licensed medical professional who:

1. Is licensed by the state in which he/she is located;
2. Is acting within the lawful scope of his/her license; and
3. Provides a health care service that we determine to be a covered expense under the policy.

Placed For Adoption: any of the following:

1. The Wisconsin Department of Children and Families, a county department under Wis. Stat § 48.57(1)(e) or (hm), or a child welfare agency licensed under § 48.60 places a child in a policyholder's home for adoption and enters into an agreement under § 48.63 (3) (b) 4. Or § 48.833 (1) or (2) with the policyholder;
2. The Wisconsin Department of Children and Families, a county department under Wis. Stat. § 48.57 (1) (e) or (hm), or a child welfare agency under § 48.837(1r) places, or a court under § 48.837 (4)(d) or (6)(b) orders, a child placed in a policyholder's home for adoption;
3. A sending agency, as defined in Wis. Stat. § 48.988 (2)(d), places a child in a policyholder's home under § 48.988 for adoption, or a public child placing agency, as defined in § 48.99 (2)(r), or a private child placing agency, as defined in § 48.99 (2)(p), of a sending state, as defined in § 48.99 (2)(w), places a child in the policyholder's home under § 48.99 as a preliminary step to a possible adoption, and the policyholder takes physical custody of the child at any location within the United States;
4. The person bringing the child into this state has complied with Wis. Stat. § 48.98, and the policyholder takes physical custody of the child at any location within the United States; or
5. A court of a foreign jurisdiction appoints a policyholder as guardian of a child who is a citizen of that jurisdiction, and the child arrives in the policyholder's home for the purpose of adoption by the policyholder under Wis. Stat. § 48.839.

Preventive Care Services: health care services that are designed to: (1) evaluate or assess health and well-being, (2) screen for possible detection of unrevealed illness, (3) improve health, or (4) extend life expectancy, and that are not for the diagnosis or treatment of an illness or injury.

Primary Care Physician: a physician who directly provides or coordinates a range of health care services for a patient. A primary care physician's primary practice is Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology and Pediatrics. A physician assistant, nurse practitioner, or certified nurse midwife may also act as a primary care physician.

Prior Authorization: written approval that you must receive from us before you visit certain health care providers or receive certain health care services. Each prior authorization will state the type and extent of the treatment or other health care services that we have authorized.

Psychologist: a person who: (1) has received a doctoral degree in psychology from an accredited college or university; (2) is licensed by the state in which he/she is located; and (3) provides health care services while he/she is acting within the lawful scope of his/her license. A doctoral degree in psychology means a Doctor of Philosophy (Ph. D) or Doctor of Psychology (Psy. D) degree that involves the application of principles of the practice of psychology that is recognized by the American Psychological Association.

Reconstructive Surgery: surgery performed on abnormal structures of the body caused by: (1) congenital defects; (2) development abnormalities; (3) trauma; (4) infection; (5) tumors; or (6) disease. The presence of a psychological condition alone will not entitle you to coverage for reconstructive surgery.

Rehabilitative Services: health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Services: hospital services, surgical services, maternity services, medical services or any other service directly provided to you by a health care provider, as determined by us.

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

Skilled Nursing Care: health care services that: (1) are furnished pursuant to a physician's orders; (2) require the skills of professional personnel such as a registered nurse or a licensed practical nurse; and (3) provided either directly by or under the direct supervision of such professional personnel.

Skilled Nursing Facility: an institution or a designated part of one, including but not limited to, a sub-acute or rehabilitation facility that:

1. Is operating pursuant to state and federal law;
2. Is under the full time supervision of a physician or registered nurse;
3. Provides services seven days a week, 24 hours a day, including skilled nursing care and therapies for the recovery of health or physical strength;
4. Is not a place primarily for custodial or maintenance care;
5. Requires compensation from its patients;
6. Admits patients only upon a physician's orders;
7. Has an agreement to have a physician's services available when needed;
8. Maintains adequate records for all patients; and
9. Has a written transfer agreement with at least one hospital.

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

Specialty Physician: any physician whose primary practice is not one of the following: Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology and Pediatrics.

Supplies: medical supplies, durable medical equipment or other materials provided directly to you by a health care provider, as determined by us.

Supportive Care: health care services provided to a covered person whose recovery has slowed or ceased entirely so that only minimal rehabilitative gains can be demonstrated with continuation of such health care services.

Surgical Services: (1) an operative procedure performed by a physician that we recognize as treatment of an illness or injury; or (2) those services we identify as surgical services, including sterilization procedures and preoperative and postoperative care. Surgical services do not include: (1) the reversal of a sterilization procedure; (2) oral surgery; and (3) maternity services.

Telehealth: the delivery of health care services, the provision of health care information, and the transfer of medical data via telecommunications technologies, including but not limited to, telephone, interactive audio and video conferencing, and email. Telehealth does not include teleradiology.

Therapy Visit: a meeting between you and a physician, licensed physical, speech, or occupational therapist or any other health care provider approved by us that: (1) occurs in the provider's office, a medical clinic, convenient care clinic, a free-standing urgent care center, skilled nursing facility, or the outpatient department of a hospital, other than a hospital's emergency room; and (2) involves you receiving physical, speech, occupational, or massage therapy.

Totally Disabled/Total Disability: being unable due to illness or injury to perform the essential functions of any job or, for dependents and retirees, to carry on most of the normal activities of a person of the same age and sex, as determined by us. You are not totally disabled if you are working on either a full-time or part-time basis for wage or profit for anyone, including working for yourself. To qualify as a totally disabled person, you must be under the regular care of a physician. We have the right to examine any covered person who claim that he/she is totally disabled as often as reasonably required for us to determine whether or not that person meets this definition. Such examinations may include, having health care providers or vocational experts examine that person.

Treatment: management and care directly provided to you by a physician or other health care provider for purposes of diagnosing, healing, curing, and/or combating an illness or injury, as determined by us.

Urgent Care: care received for an illness or injury with symptoms of sudden or recent onset that require medical care the same day.

Waiting Period: a period of time that must pass before an individual is eligible to be covered for benefits under the provisions of the policy.

We, Us, Our: WPS Health Plan, Inc. d/b/a Arise Health Plan.

You, Your: a covered person.

ELIGIBILITY

Employees

An employee is eligible for coverage under the policy if he/she meets the definition of "eligible employee" in section "DEFINITIONS."

A policyholder may also request to make coverage available to certain 1099 employees by indicating this preference on its Employer's Group Application.

An eligible employee may be subject to a waiting period, as indicated on the policyholder's current Arise Health Plan application for coverage.

An individual who ceases to qualify as an eligible employee may continue coverage under the policy in certain circumstances. See section "WHEN COVERAGE ENDS" / "Extension of Coverage" for more details.

Dependents

An individual is eligible for coverage under the policy if he/she meets the definition of “dependent” in section “DEFINITIONS” unless he/she is:

1. Covered under the policy as a covered employee; or
2. On active duty with the military service, including national guard or reserves, other than for duty of less than 30 days.

A dependent is eligible for coverage when:

1. The employee becomes eligible for coverage, if he/she has dependents who may be covered on that date;
2. The dependent loses eligibility for Medicaid, including BadgerCare Plus or CHIP; and/or
3. The dependent becomes eligible for premium assistance subsidy under Medicaid, including BadgerCare Plus or CHIP.

In addition, certain categories of dependents are eligible for coverage as follows:

1. A covered employee’s new spouse and/or stepchildren are eligible for coverage on the date of the covered employee’s marriage;
2. A covered employee’s natural child is eligible for coverage on the date of his/her birth;
3. An adopted child is eligible for coverage on the date the child is placed for adoption under the covered employee’s legal guardianship or the date that a court issues a final order granting adoption of the child to the covered employee, whichever occurs first;
4. A dependent who was a full-time student and was called to federal active duty prior to age 27 is eligible for coverage on the date that he/she becomes a full-time student again; and
5. A child born to a covered employee’s covered dependent child who is under the age of 18 is eligible for coverage on his/her date of birth.

ENROLLMENT AND EFFECTIVE DATE

Eligible Employees

To enroll for coverage under the policy, an eligible employee must complete and submit the applicable enrollment form available from his/her employer within:

1. 31 days of becoming eligible;
2. 60 days of the loss of eligibility for Medicaid, including BadgerCare Plus or CHIP; or
3. 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus or CHIP has been determined.

If an eligible employee does not enroll for coverage within these timeframes and he/she is not otherwise eligible for a special enrollment period, he/she must wait to enroll for coverage during the next annual enrollment period.

An eligible employee's effective date of coverage will be based on the following:

1. If an eligible employee enrolls for coverage under the policy within 30 days of becoming eligible, his/her effective date of coverage will be the date he/she is initially eligible.
2. If an eligible employee enrolls for coverage within 60 days after the loss of eligibility for Medicaid, including BadgerCare Plus, or CHIP, his/her effective date of coverage is the first day of the month following our receipt of the request for enrollment,
3. If an eligible employee enrolls for coverage within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, or CHIP has been determined, his/her effective date of coverage is the first day of the month following our receipt of the request for enrollment.

If an eligible employee is not actively at work for reasons other than illness or injury on the date his/her coverage would begin, his/her health coverage will not be effective until the day he/she returns to active work.

Eligible Dependents

To enroll a dependent for coverage under the policy, a covered employee must complete and submit the applicable enrollment form available from his/her employer within:

1. 31 days of becoming eligible;
2. 60 days after the loss of eligibility for Medicaid, including BadgerCare Plus or CHIP; or
3. 60 days after eligibility for premium assistance subsidy under Medicaid including BadgerCare Plus or CHIP has been determined.

If an eligible dependent does not enroll for coverage within these timeframes and he/she is not otherwise eligible for a special enrollment period, he/she must wait to enroll for coverage during the next annual enrollment period.

Each eligible dependent's effective date of coverage will be based on the following:

1. If an eligible dependent enrolls for coverage under the policy within 31 days of becoming eligible, his/her effective date of coverage will be the date he/she is initially eligible, unless specifically stated otherwise below.
2. If an eligible dependent enrolls for coverage within 60 days after the loss of eligibility for Medicaid, including BadgerCare Plus or CHIP, his/her effective date of coverage is the first day of the month following our receipt of the request for enrollment,
3. If an eligible dependent enrolls for coverage within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus or CHIP has been determined, his/her effective date of coverage is the first day of the month following our receipt of the request for enrollment.

Annual Enrollment Period

Each year an employee will have an enrollment period in which he/she and his/her dependents who did not enroll under the policy when first eligible can enroll under the policy. The annual enrollment period also provides an opportunity for a covered employee to change to a different health insurance plan, if available.

If an employee or dependent does not request enrollment during the annual enrollment period, he/she must wait to enroll for coverage during the next annual enrollment period unless he/she becomes eligible for special enrollment.

The annual enrollment period will be the month prior to the policyholder's anniversary date.

Special Enrollment Provisions

1. Late Enrollment Arising from Loss of Other Coverage.

If an employee and/or his/her dependents are not covered under the policy but are otherwise eligible for coverage, the employee may enroll himself/herself and/or his/her eligible dependents if all of the following apply:

- a.** The employee submitted an enrollment form within 30 days of their initial date of eligibility and waived the benefits of the policy for himself/herself and/or his/her eligible dependents because the employee and/or dependents had other health coverage;
- b.** The employee and/or his/her dependents were either eligible for coverage or were covered by another policy when the employee initially waived the benefits of the policy;
- c.** The employee and/or dependents lost coverage for himself/herself and/or his/her dependents under the other group health plan or qualifying health insurance coverage that the employee and/or dependent had when he/she waived the benefits of the policy; and
- d.** We received the employee's enrollment request for himself/herself and/or his/her eligible dependents within 30 days after the employee's other health coverage ended.

Under these circumstances, coverage for the employee and/or his/her dependents will begin on the first day of the calendar month following the date the employee's other health coverage ended.

2. Other Special Late Enrollment Circumstances.

If the employee is an active member of the eligible class of employees and has completed any waiting period required by the policyholder, he/she may enroll himself/herself and his/her eligible dependents if the employee acquires an eligible dependent through marriage, birth of a child, adoption or placement for adoption of a child or by court order.

We must receive an enrollment form from the employee, listing all individuals for whom the employee wishes coverage, within 30 days of the date the employee experiences the special late enrollment circumstance. If we do, coverage for the employee and/or his/her eligible dependents will begin on the first day of the calendar month following the date of marriage or on the date the employee experiences the special late enrollment circumstance due to birth, adoption or placement for adoption of a child, or by court order. If we receive the employee's enrollment application after the 30-day period, the employee and/or his/her eligible dependents must apply during the annual enrollment period.

3. Change in Marital Status

If a covered employee has single coverage and wishes to change to family coverage to add an eligible spouse due to his/her marriage, we must receive an enrollment form, listing all dependents for whom the employee wishes coverage, within 30 days of the date of marriage. If we do, family coverage will be effective the first day of the calendar month following his/her date of marriage. If the enrollment form is received by us more than 30 days after his/her date of marriage, the eligible spouse and any other eligible dependents may only be added during the annual enrollment period.

4. Adding a Newborn Natural Child

If a covered employee has family coverage, coverage is provided for his/her newborn natural child from the moment of that child's birth. We request that the covered employee notify us about the child's birth.

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

If a covered employee wishes to change to family coverage to add his/her newborn natural child, we must receive an enrollment form, listing all dependents for whom the employee wishes coverage, within either of the following enrollment periods: (a) within the first 60 days after the birth of his/her natural child; or (b) within one year after the birth of his/her natural child. If the covered employee chooses option (b), he/she must pay all required past-due premiums that have accrued since the child's date of birth plus interest on such premiums at a rate of 5 1/2% per year. The effective date for such family coverage will be the date of that child's birth. If the enrollment form is received by us after his/her enrollment period ends, his/her newborn natural child and any other eligible dependents may only be added during the annual enrollment period.

5. Changing from Single to Family Coverage Because of Adoption.

If a covered employee has single coverage and wishes to change to family coverage because of his/her adoption of a child or a child placed for adoption, we must receive an enrollment form, listing all dependents for whom the employee wishes coverage, within the 60-day enrollment period following the date of such adoption or placement for adoption. The effective date for such family coverage will be one of the following: (a) the date a court makes a final order granting adoption of the child by the covered employee; (b) on the date that the child is placed for adoption with the covered employee; or (c) a later date elected by the covered employee. If the enrollment form is received by us after his/her enrollment period ends, his/her new dependents may only be added during the annual enrollment period.

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

6. Changing From Single to Family Coverage or Adding a Dependent Due to a Court Order

To the extent required by Wis. Stat. § 632.897 (10) (am), a covered employee may change from single coverage to family coverage to cover the health care expenses of his/her child if a court orders him/her to do so and if we determine that the child is eligible to be a dependent under the policy.

In order to obtain coverage, the covered employee, the child's other parent, the Wisconsin Department of Children and Families, or the county child support agency under Wis. Stat. § 59.53(5) must submit the following to us after the applicable court order is issued: (a) a completed

enrollment form listing all dependents for whom the employee wishes coverage; (b) a copy of the court order; and (c) payment for the appropriate premium.

The effective date of family coverage under this paragraph will be either (a) the date that court order is issued; or (b) another coverage date contained in that court order. Such coverage will continue in effect until the earliest of the following dates:

- a. the date upon which the covered employee is no longer eligible for family coverage under the policy;
- b. the date upon which the court order expires;
- c. the date upon which the dependent child obtains coverage under another group policy or individual policy that provides comparable health care coverage, as applicable; or
- d. the date upon which the dependent child's coverage ends sooner in accordance with section "WHEN COVERAGE ENDS."

The covered employee must notify us in writing as soon as reasonably possible after he/she becomes aware that the applicable court order is expiring and/or that other coverage is becoming effective for that child.

Reinstatement of All Coverage

If a covered employee's coverage ends due to termination of employment, leave of absence, or lay-off, and he/she later returns to active work, he/she must meet the waiting period for a new employee. However, the waiting period requirement does not apply if his/her coverage ends due to leave of absence or lay-off and he/she returns to active work within 90 days from the day his/her leave of absence or lay-off began.

PAYMENT OF BENEFITS

Any payment of benefits is subject to: (1) the applicable deductible amount; (2) coinsurance; (3) the applicable copayment amount; (4) your out-of-pocket limit; (5) exclusions; (6) our prior authorization requirements; (6) our maximum allowable fee; (7) all other limitations shown in the Schedule of Benefits; and (8) all other terms, conditions and provisions of the policy.

Deductible Amounts

Each year, you are required to pay a certain amount of charges out-of-pocket before most benefits are payable under the policy. These out-of-pocket amounts are called deductibles.

Your deductible amounts are shown in the Schedule of Benefits. No benefits are payable under the policy for charges used to satisfy your deductible amount.

After you reach your applicable deductible amount, most charges for covered expenses will still be subject to any copayment and/or coinsurance amounts shown in your Schedule of Benefits.

The participating provider and non-participating provider deductibles are separate. However, charges for health care services provided by a non-participating provider and paid at the participating provider level of benefits shall be applied to the participating provider annual deductible amount shown in the Schedule of Benefits.

Coinsurance

Coinsurance is your share of the costs of a covered health care service, calculated as a percent of the covered expense. After you satisfy your deductible, you will only be responsible for the copayment amount and coinsurance percentage shown in the Schedule of Benefits. The coinsurance percentage, if any, applies unless you have reached your out-of-pocket limit. See subsection “Out-of-Pocket Limits” for additional information on your out-of-pocket limit.

Copayments

A copayment is the fixed amount you pay for a covered health care service, usually when you receive the service. As set forth below and if shown in your Schedule of Benefits, the copayment amount will vary by the type of service. You may also have a copayment when you get a prescription filled. See subsection “Prescription Legend Drugs” for information about prescription copayments.

If you receive a health care service at a hospital-based outpatient clinic or location, your bill may show two separate charges – one for the health care provider and one for the facility. The copayment only applies to the charge billed by the health care provider. Facility charges are subject to the applicable annual deductible and coinsurance amounts of the policy.

Out-of-Pocket Limits

The out-of-pocket limit is the maximum out-of-pocket amount that you are required to pay each calendar year for covered health care services. This limit is shown in the Schedule of Benefits.

Any of the following costs will count towards your out-of-pocket limit: (1) the deductible; (2) copayments; and (3) coinsurance amounts you pay for covered expenses associated with health care services provided by a participating provider or non-participating provider.

In determining whether you've reached your out-of-pocket limit, the following amounts will not count:

1. Amounts you pay for non-covered health care services; and
2. Amounts you pay that exceed our determination of the maximum allowable fee.

After your out-of-pocket limit is reached, we will pay 100% of the charges up to the maximum allowable fee for covered health care services you receive from a participating provider or non-participating provider during the remainder of the calendar year, subject to all other terms, conditions and provisions of the policy.

Charges for health care services provided by a non-participating provider and paid at the participating provider level of benefits shall be applied to the participating provider out-of-pocket limit shown in the Schedule of Benefits.

Maximum Allowable Fee

We'll pay charges for the covered expenses described in section “Covered Expenses” up to the maximum allowable fee. If you see a non-participating provider, you are solely responsible for paying any charge that exceeds the maximum out-of-network allowable fee. Regardless of what health care provider you see, you are also solely responsible for paying any charge for a health care service that we do not cover under the policy.

You may contact us before receiving a health care service to determine if the health care provider's estimated charge is less than or equal to the maximum allowable fee. In order for us to make this

determination you will need to provide us with the following information: (1) the estimated amount that your health care provider will bill for the health care service; and (2) the CPT code, if applicable.

COVERED EXPENSES

Health care services described in this section are covered expenses as long as they are:

1. Medically necessary;
2. Ordered by a physician for a covered illness, covered injury, or for preventive care;
3. Provided by any health care provider licensed to provide a health care service covered under the policy.

If the health care service is not listed in this section, that health care service is not covered and no benefits are payable under the policy.

Please note that any of the health care services listed below may be subject to a prior authorization requirement. Please see section "OBTAINING SERVICES" for detailed information about our prior authorization requirements.

Benefits are not payable for maintenance care, custodial care, supportive care, or any health care service to which an exclusion applies. Please see section "EXCLUSIONS AND LIMITATIONS" for detailed information about the policy's exclusions.

All benefits are subject to the deductible and coinsurance amounts, copayment amounts, out-of-pocket limits and all other provisions stated in the Schedule of Benefits.

Alcoholism Treatment

See subsection "Behavioral Health Services" for benefits for alcoholism treatment.

Allergy Testing and Treatment

Therapy and testing for treatment of allergies.

Alternative Care

If your attending physician advises you to consider alternative care for a covered illness or injury that includes health care services not covered under the policy, your attending physician should contact us so we can discuss it with him/her. We, in our sole discretion, will consider paying such non-covered health care services as long as they are medically necessary to treat your illness or injury.

We may consider an alternative care plan if the alternative care is not subject to an exclusion of the policy and we find that:

1. The recommended alternative care offers a medical therapeutic value equal to or greater than the current treatment or confinement;
2. The current treatment or confinement is covered under the policy;
3. The current treatment or confinement may be changed without jeopardizing your health; and

4. The charges incurred for health care services provided under the alternative care plan will be less than those charges for health care services provided under the current treatment or confinement plan.

We will make each alternative care coverage determination on a case by case basis and no decision will set any precedent for future claims. Payment of benefits, if any, shall be determined by us.

Any alternate care decision must be approved by you, the attending physician, and us before such alternate care begins.

Ambulance Services

Ambulance services used to transport you when you are sick or injured:

1. From your home or the scene of an accident or medical emergency to a hospital;
2. Between hospitals;
3. Between a hospital and a skilled nursing facility; or
4. From a hospital or a skilled nursing facility to your home.

Your ambulance services benefits include coverage of any emergency medical care directly provided to you during your ambulance transport. In other words, if the ambulance service bills emergency medical care along with transport services, benefits are payable as stated in this subsection. If, however, the ambulance service bills emergency medical care separate from the transport services, benefits shall be payable as stated elsewhere in the applicable provisions of the policy.

Ambulance transports must be made to the closest local facility that can provide health care services appropriate for your illness or injury, as determined by us. If none of these facilities are located in your local area, you are covered for transports to the closest facility outside your local area.

Benefits are not payable for ambulance services:

1. When you can use another type of transportation without endangering your health;
2. When ambulance services are used solely for the personal convenience or preference of you, a family member, physician, or other health care provider; and
3. When ambulance services are provided by anyone other than a licensed ambulance service.

Anesthesia Services

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

Autism Services

1. **Definitions.**

The following definitions apply to this subsection only:

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

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

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

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

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

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

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

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

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

- a. 1,500 hours supervised training involving direct one-on-one work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models;
- b. supervised experience with all of the following:
 - (1) working with families as part of a treatment team and ensuring treatment compliance;
 - (2) treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
 - (3) treating individuals with autism spectrum disorders with a variety of behavioral challenges;

- (4) treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and
 - (5) designing and implementing progressive treatment programs for individuals with autism spectrum disorders.
- c. academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

Qualified Intensive-Level Provider: an individual identified in Wis. Stat. § 632.895 (12m) (b) 1. to 4, respectively, acting within the scope of a currently valid state-issued license for psychiatry, psychology or behavior analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy, who provides evidence-based behavioral therapy in accordance with this section and Wis. Admin. Code INS 3.36 and Wis. Stat. § 632.895 (12m) (a) 3., and who has completed at least 2,080 hours of training, education and experience which includes all of the following:

- a. 1,500 hours supervised training involving direct one-on-one work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models;
- b. supervised experience with all of the following:
 - (1) working with families as the primary provider and ensuring treatment compliance;
 - (2) treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
 - (3) treating individuals with autism spectrum disorders with a variety of behavioral challenges;
 - (4) treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and
 - (5) designing and implementing progressive treatment programs for individuals with autism spectrum disorders.
- c. academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

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

- a. is at least 18 years of age;
- b. obtains a high school diploma;
- c. completes a criminal background check;
- d. obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid;

- e. obtains at least 10 hours of training in the use of behavioral evidence-based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present; and
- f. receives regular, scheduled oversight by a qualified provider in implementing the treatment plan for you.

Qualified Professional: a professional working under the supervision of an outpatient mental health clinic certified under Wis. Stat. § 51.038, acting within the scope of a currently valid state-issued license and providing evidence-based therapy in accordance with Wis. Admin Code INS 3.36.

Qualified Provider: an individual identified under Wis. Stat. § 632.895 (12m) (b) 1. to 4., acting within the scope of a currently valid state-issued license for psychiatry, psychology, behavior analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy and who provides evidence-based therapy in accordance with Wis. Admin Code INS 3.36.

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

Qualified Therapist: a speech-language pathologist or occupational therapist acting within the scope of a currently valid state issued license and who provides evidence-based therapy in accordance with Wis. Admin Code INS 3.36.

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

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

2. **Benefits.**

Benefits are payable for charges for covered expenses as described in this subsection for covered persons who have a verified diagnosis of autism spectrum disorder made by a diagnostician skilled in testing and in the use of empirically-validated tools specific for autism spectrum disorders. Services must be prescribed by a physician and provided by any of the following who are qualified to provide intensive level services or nonintensive-level services: (a) a qualified intensive-level provider; (b) a qualified paraprofessional under the supervision of a qualified supervising provider; (c) a qualified intensive-level professional; or (d) a qualified therapist. Your progress must be assessed and documented throughout your course of treatment.

The benefits under this subsection do not include benefits for durable medical equipment and prescription legend drugs. For coverage of durable medical equipment and prescription legend drugs, see subsection "Durable Medical Equipment" and subsection "Prescription Legend Drugs."

Benefits are payable for the following:

- a. **Intensive-Level Services.** Benefits are payable for charges for intensive-level services that meet all of the following requirements:
 - (1) the majority of such services are provided to you when your parent or legal guardian is present and engaged;

- (2) the services are based upon a treatment plan developed by an individual who at least meets the requirements of a qualified intensive-level provider or a qualified intensive-level professional that includes at least 20 hours per week over a six-month period of time of intensive-level evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that you be present and engaged in the intervention. We may request and review your treatment plan and the summary of progress on a periodic basis;
- (3) the services are implemented by qualified providers, qualified professionals, qualified therapists or qualified paraprofessionals;
- (4) the services are provided in an environment most conducive to achieving the goals of your treatment plan;
- (5) the services implement identified therapeutic goals by the team including training and consultation, participation in team meetings and active involvement of your family;
- (6) the services begin after you are two years of age and before you are nine years of age; and
- (7) the services are provided by a qualified intensive-level provider or qualified intensive-level professional who directly observes you at least once every two months.

Benefits are also payable for intensive-level services provided by a qualified therapist if all of the following requirements are met:

- (1) the services are rendered concomitant with intensive-level evidence-based behavioral therapy;
- (2) the qualified therapist provides evidence-based therapy to a covered person who has a primary diagnosis of autism spectrum disorder;
- (3) you are actively receiving behavioral therapy from a qualified intensive-level provider or qualified intensive-level professional; and
- (4) the qualified therapist develops and implements a treatment plan consistent with his/her license.

b. Nonintensive-Level Services. Benefits are payable for charges for nonintensive-level evidence-based therapy services provided to you by someone who is at least a qualified provider, qualified professional, qualified therapist or qualified paraprofessional in either of the following situations:

- (1) after the completion of intensive-level services, provided that such non-intensive level services are designed to sustain and maximize gains made during intensive-level services treatment; or
- (2) to you if you have not and will not receive intensive-level services but for whom nonintensive-level services will improve his/her condition.

All nonintensive level services must:

- (1) be based upon a treatment plan developed by an individual who is at least a qualified provider, a qualified professional or qualified therapist that includes specific evidence-based therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that you be present and engaged in the intervention. We may request and review your treatment plan and the summary of progress on a periodic basis;
- (2) be implemented by a person who is at least a qualified provider, qualified professional, qualified therapist or qualified paraprofessional;
- (3) be provided in the environment most conducive to achieving the goals of your treatment plan; and
- (4) implement identified therapeutic goals developed by the team including training and consultation, participation in team meetings and active involvement of your family.

c. Transition from Intensive-Level Services to Nonintensive-Level Services. We will provide you, or your authorized representative, with notice regarding any change in the level of treatment covered under the policy. The notice will explain the reason for the transition which may include any of the following:

- (1) you no longer require intensive-level services as supported by documentation from a qualified intensive-level provider, qualified intensive-level professional or a qualified supervising provider; or
- (2) you no longer receive evidence-based therapy for at least 20 hours per week over a six month period of time.

You or your representative should promptly notify us if you qualify for intensive-level services but are unable to receive them for an extended period of time. The notification must indicate the specific reason or reasons you or your family or care giver is unable to comply with an intensive-level service treatment plan. Reasons for requesting an interruption of intensive-level services for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason that we determine to be acceptable. We will not deny intensive-level services to you for failing to maintain at least 20 hours per week of evidence based behavioral therapy over a six-month period when: (1) you notify us as stated above; or (2) you or your authorized representative can document that you failed to maintain at least 20 hours per week of evidence-based behavioral therapy due to waiting for waiver program services.

3. Exclusions.

This subsection is not subject to the exclusions in section "EXCLUSIONS AND LIMITATIONS." This subsection is subject to the following exclusions. The policy provides no benefits for:

- a. acupuncture;
- b. animal-based therapy including hippotherapy;
- c. auditory integration training;
- d. chelation therapy;
- e. child care fees;

- f. cranial sacral therapy;
- g. hyperbaric oxygen therapy;
- h. custodial or respite care;
- i. special diets or supplements;
- j. travel time by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals;
- k. therapy, treatment or services when provided to a covered person who is residing in a residential treatment center, inpatient treatment or day treatment facility;
- l. costs for the facility or location or for the use of a facility or location when treatment, therapy or services are provided outside of your home;
- m. claims that have been determined by us to be fraudulent; and
- n. treatment provided by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessionals for treatment provided to their own children.

Behavioral Health Services

1. Definitions.

The following definitions apply to this subsection only:

Collateral: a member of your immediate family.

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

Hospital: (a) a hospital licensed under Wis. Stat. §50.35; (b) an approved private treatment facility as defined in Wis. Stat. §51.45 (2) (b); or (c) an approved public treatment facility as defined in Wis. Stat. §51.45 (2)(c).

Inpatient Hospital Services: services for the treatment of nervous or mental disorders, alcoholism or drug abuse that are directly provided to a covered person who is a bed patient in the hospital. However this definition shall not include those inpatient hospital services for detoxification of drug addiction or alcohol dependency. Please see subsection "Hospital Services."

Licensed Mental Health Professional: a clinical social worker licensed under Wis. Stat. §457.08, a marriage and family therapist licensed under §457.10, or a professional counselor licensed under §457.12.

Outpatient Services: nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse problems directly provided to a covered person and, if for the purpose of enhancing his/her treatment, a collateral by any of the following: (a) a program in an outpatient treatment facility, if both the program and facility are approved by the Department of Health Services and established and maintained according to rules promulgated under Wis. Stat. s. 51.42 (7)(b); (b) a licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office; (c) a psychologist licensed or certified by the

state in which he/she is located; (d) a licensed mental health professional practicing within the scope of his/her license under Wis. Stat. Chapter 457 and applicable rules; or (e) a health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse within the scope of that license.

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

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

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

- a. mental health services for covered adults in a day treatment program;
- b. mental health services for covered children and adolescents in a day treatment program;
- c. services for covered persons with chronic mental illness provided through a community support program;
- d. residential treatment programs for treatment of a covered person's nervous or mental disorders and for alcohol or drug-dependent covered persons or both;
- e. services for alcoholism and other drug problems provided in a day treatment program;
- f. intensive outpatient programs for narcotic treatment services for opiate addiction and for treatment of nervous or mental disorders;
- g. coordinated emergency mental health services which are provided by a licensed mental health professional for covered persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided; and
- h. out-of-state services and programs that are substantially similar to a. through g. above if the provider is in compliance with similar requirements of the state in which the health care provider is located.

The criteria that we use to determine if a transitional treatment is medically necessary and covered under the policy include, but are not limited to, whether:

- a. the transitional treatment is certified by the Department of Health Services;
- b. the transitional treatment meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;
- c. the specific diagnosis is consistent with the symptoms;
- d. the transitional treatment is standard medical practice and appropriate for the specific diagnosis;
- e. the transitional treatment plan is focused for the specific diagnosis; and

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

We will need the following information from the health care provider to help us determine the medical necessity of a transitional treatment:

- a. a summary of the development of your illness and previous treatment;
- b. a well-defined treatment plan listing treatment objections, goals and duration of the care provided under the transitional treatment program; and
- c. a list of credentials for the staff who participated in the transitional treatment program or service, unless the program or service is certified by the Department of Health Services.

2. Benefits.

We'll pay benefits for charges for covered expenses you incur for inpatient hospital services, outpatient services and transitional treatment that you receive each calendar year.

No benefits are payable for charges for outpatient services provided to or received by a covered person as a collateral of a patient when those outpatient services do not enhance the outpatient treatment of another covered person who is also insured under the policy.

Blood and Blood Plasma

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

Cardiac Rehabilitation Services

Cardiac rehabilitation services limited to the following:

1. Phase I, while you are confined as an inpatient in a hospital;
2. Phase II, while you are an outpatient receiving services in a facility with a facility-approved cardiac rehabilitation program.

Benefits are payable for charges for up to 36 supervised and monitored exercise sessions per covered illness starting with the first session in the outpatient exercise program.

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

Chiropractic Services

Spinal manipulations and diagnostic tests provided by a chiropractor.

For therapy benefits, please see subsection "Therapy Services."

Clinical Trials

1. Definitions.

The following definitions apply to this subsection only:

Life-Threatening Condition: any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualifying Clinical Trial: a clinical trial that meets the definition of an “approved clinical trial” under Section 2709(d) (1) of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act.

Routine Patient Care Costs: costs associated with any of the following:

- a. health care services that are typically covered under the policy absent a clinical trial;
- b. covered health care services required solely for the provision of the trial health care service and clinically appropriate monitoring of the effects of the health care service trial;
- c. reasonable and necessary health care services used to diagnose and treat complications arising from your participation in a qualifying clinical trial; or
- d. covered health care services needed for reasonable and necessary care arising from the provision of a trial health care service.

Routine patient care costs do not include costs associated with:

- a. experimental/investigational/unproven health care services with the exception of: (1) certain Category B devices; (2) certain promising interventions for patients with terminal illnesses; and (3) other health care services that meet specified criteria in accordance with our medical policy guidelines;
- b. health care services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- c. health care services provided by the research sponsors at no charge to any person enrolled in the trial; or
- d. health care services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

2. **Benefits.**

Routine patient care costs that you incur while participating in a qualifying clinical trial for the treatment of cancer or other life-threatening conditions.

Benefits are available only when you are eligible to participate in an approved clinical trial according to trial protocol.

Colonoscopies

Diagnostic and routine screening colonoscopies and high risk screening colonoscopies based on the most current Colorectal Cancer Screening guidelines from the United States Preventive Services Task Force.

For purposes of this benefit, the term colonoscopy also includes fecal occult blood testing and flexible sigmoidoscopy. Coverage does not include virtual colonoscopy or CT colonography unless we determine that an optical colonoscopy cannot be done safely or that there is a potential lack of effectiveness as determined by us;

1. Routine Screening Colonoscopy.

A routine screening colonoscopy is a procedure performed for detection of a clinically unrevealed illness, subject to appropriate time intervals provided in the most current guidelines from the United States Preventive Services Task Force. When a service is performed for the purpose of preventive screening and is appropriately reported, it will be adjudicated as a preventive care service.

Preventive services are those performed on a person who:

- a.** has not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities;
- b.** has had screening done within the recommended interval with the findings considered normal;
- c.** has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals; or
- d.** has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service.

For example, if a polyp is encountered during a preventive screening colonoscopy, the colonoscopy, removal of the polyp, and associated facility, lab and anesthesia fees done at the same encounter are covered under the preventive care services benefit.

2. Diagnostic Colonoscopy.

When a colonoscopy is done for diagnostic purposes it will be adjudicated under the applicable non-preventive medical benefit, and any deductible, copayment, and coinsurance will apply.

Diagnostic services are those performed on a person who:

- a.** had abnormalities found on previous preventive or diagnostic studies that require further diagnostic studies;
- b.** had abnormalities found on previous preventive or diagnostic studies that would recommend a repeat of the same studies within shortened time intervals from the recommended preventive screening time intervals; or
- c.** had a symptom(s) that required further diagnosis.

For example, if a patient had a polyp found and removed at a prior preventive screening colonoscopy, all future colonoscopies are considered diagnostic because the time intervals between future colonoscopies would be shortened.

3. High-Risk Screening Colonoscopy.

A high-risk screening colonoscopy is a procedure performed on a person who has any of the following risk factors:

- a.** personal history of colorectal cancer, polyps, or chronic inflammatory bowel disease;
- b.** strong family history in a first-degree relative or two or more second-degree relatives of colorectal cancer or polyps;
- c.** personal history or family history in a first or second-degree relative of hereditary colorectal cancer syndromes; or

- d. other conditions, symptoms, or diseases that are recognized as elevating one's risk for colorectal cancer as determined by the United States Preventive Services Task Force.

A high-risk screening colonoscopy that meets the most current guidelines from the United States Preventive Services Task Force for routine screening (e.g., strong family history of colorectal cancer in a first-degree relative) will be subject to the preventive care services benefit.

Contraceptives for Birth Control

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

1. Intrauterine devices (IUD);
2. Subdermal contraceptive implants;
3. Injections of medication for birth control; and
4. Contraceptive devices obtained directly from your physician.

For coverage of additional contraceptives, including, but not limited to, oral contraceptives, contraceptive patches, diaphragms and contraceptive vaginal rings, see subsection "Prescription Legend Drugs."

Dental Services

Dental services, limited to the following:

1. Dental repair or replacement of your sound natural teeth due to an injury, provided treatment begins within six months of the injury. Benefits for treatment of an injury are limited to the following:
 - a. emergency examination;
 - b. necessary diagnostic X-rays;
 - c. endodontic (root canal) treatment;
 - d. temporary splinting of teeth;
 - e. prefabricated post and core;
 - f. simple minimal restorative procedures (fillings);
 - g. extractions;
 - h. post-traumatic crowns if such are the only clinically acceptable treatment; and
 - i. replacement of lost teeth due to the injury by implant, dentures or bridges.
2. Hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to you in a hospital or ambulatory surgery center if you:
 - a. are a child under the age of five;

- b. have a chronic disability that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is likely to continue indefinitely; and (3) results in substantial functional limitations in one or more of the following area of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or
 - c. have a medical condition that requires hospitalization or general anesthesia for dental care.
- 3. Dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the policy, limited to: (a) transplant preparation; (b) prior to the initiation of immunosuppressive drugs; and (c) the direct treatment of acute traumatic injury, cancer or cleft palate.
- 4. Orthognathic surgery for the treatment of obstructive sleep apnea.

Benefits are not payable for cosmetic treatment or elective orthodontic care, orthognathic care (other than as stated above), periodontal care, oral surgery for bony impacted wisdom teeth or general dental care.

Diabetes Treatment

Installation and use of an insulin infusion pump, and all other equipment and supplies used in the treatment of diabetes, excluding insulin. For coverage of insulin, see subsection "Prescription Legend Drugs and Supplies."

Benefits for insulin syringes and needles, lancets, diabetic test strips, alcohol pads, dextrose (tablets and gel), auto injector, auto blood sampler, and glucose control solution are only covered under this subsection when they are dispensed by a health care provider other than a pharmacy. When such disposable supplies are dispensed by a pharmacy, benefits are payable according to subsection "Prescription Legend Drugs and Supplies."

This benefit is limited to the purchase of one insulin infusion pump per covered person per calendar year, provided the replacement is medically necessary as determined by us. We'll also pay benefits for charges for diabetic self-management education programs, but only if we determine that the program is medically necessary.

Diagnostic Services

Diagnostic x-rays, radiology and laboratory services directly provided to you for radiology and lab tests related to a covered physical illness or injury. Charges for computer-aided detection are not payable under the policy (except for screening mammogram interpretation).

Drug Abuse Treatment

See subsection "Behavioral Health Services" for benefits for drug abuse treatment.

Durable Medical Equipment

Rental of or, at our option, purchase of durable medical equipment, subject to the following:

- 1. The durable medical equipment must be prescribed by a physician and needed in the treatment of an illness or injury.

2. If the durable medical equipment is purchased, benefits will be payable for subsequent repairs necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be payable subject to approval by us. Subsequent repairs due to abuse or misuse, as determined by us, are not covered.
3. Benefits will be limited to the standard models, as determined by us.
4. We will pay benefits for only one of the following: a manual wheelchair, a motorized wheelchair, or a motorized scooter, as determined by us.
5. If the durable medical equipment is purchased, benefits are limited to a single purchase of each type (including repair and replacement) every three years.

We do not cover: (1) rental fees that are more than the purchase price; (2) routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of one month rental billed every six months; (3) replacement of equipment unless we determine that it is medically necessary; and (4) replacement of batteries.

Emergency Medical Care

1. Emergency Medical Care in a Hospital Emergency Room.

- a. Benefits are payable for health care services provided in a hospital emergency room as shown in the Schedule of Benefits. If a copayment is shown, this copayment applies to the emergency room fee billed by the hospital for use of the hospital emergency room. If you received health care services for an urgent care facility within a hospital, this emergency room copayment shall apply. We will waive the emergency room copayment if you are admitted as a resident patient to the hospital directly from the hospital emergency room.

If you are admitted as a resident patient to the hospital directly from the hospital emergency room, charges for covered expenses provided in the hospital emergency room shall be payable subject to the applicable deductible and coinsurance that applies to that hospital confinement.

- b. If you are outside of the geographical service area and a medical emergency arises that requires you to go to an emergency room, you are eligible for coverage regardless of which emergency room you use. If follow-up care or additional health care services are needed after the medical emergency has passed, you will need an approved prior authorization from us before receiving such services from a non-participating provider in order for services to be paid at the participating provider benefit level. Covered health care services received from a non-participating provider will be limited to the amounts that we determine to be the maximum out-of-network allowable fee. You will be responsible for the difference between the amount charged and the maximum out-of-network allowable fee.

2. Emergency Medical Care in a Place Other than a Hospital Emergency Room.

Emergency medical care received in a physician's office, urgent care facility, or any other place of service other than a hospital emergency room will be payable as shown in the Schedule of Benefits. If follow-up care or additional health care services are needed after the medical emergency has passed, you will need an approved prior authorization from us before receiving such services from a non-participating provider in order for services to be paid at the participating provider benefit level. Covered health care services received from a non-participating provider will be limited to the amounts that we determine to be the maximum out-of-network allowable fee. You will be responsible for the difference between the amount charged and the maximum out-of-network allowable fee.

Genetic Services

Genetic services, limited to the following:

1. Genetic counseling provided to you by a physician, a licensed or Master's trained genetic counselor or a medical geneticist. When genetic counseling is provided by a participating provider, benefits are payable at 100% of the charges, without application of the applicable annual deductible amount. Genetic counseling includes evaluation for BRCA testing for a female covered person whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations;
2. Amniocentesis during pregnancy;
3. Chorionic villus sampling for genetic and non-genetic testing during pregnancy;
4. Identification of infectious agents such as influenza and hepatitis. Panel testing for multiple agents is not covered unless your physician provides a justification for including each test in the panel;
5. Compatibility testing for a covered person who has been approved by us for a covered transplant;
6. Cystic fibrosis testing as recommended by the American College of Medical Genetics;
7. Molecular testing of pathological specimens. Such testing does not include any testing of blood, except testing for the diagnosis of leukemia, lymphoma, or platelet abnormalities. Molecular testing as part of a genetic panel analysis requires our prior authorization;
8. BRCA testing for a female covered person whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations. When such testing is provided by a participating provider, benefits are payable at 100% of the charges, without application of the applicable annual deductible amount; and
9. All other genetic testing, provided you receive our prior authorization. We will authorize genetic testing if your physician shows that the results of such testing will directly impact your future treatment. Your physician must describe how and why, based on the results for the genetic testing results, your individual treatment plan would be different than your current or expected treatment plan based on a clinical assessment without genetic testing. Upon request, your physician must submit information regarding the genetic testing's clinical validity and clinical utility. Genetic testing that we consider experimental/investigational/unproven will not be covered.

Health and Behavior Assessments

Health and behavior assessments and reassessments, diagnostic interviews and neuropsychological testing provided by a psychologist to treat a physical illness or injury. However, subsequent treatment of that medical condition by a psychologist will not be covered under the policy.

Hearing Aids and Implantable Hearing Devices

1. One hearing aid, per ear, per covered person once every three years;
2. Implantable hearing devices;
3. Bone anchored hearing devices limited to one device for your lifetime while you are covered under the policy, provided you:

- a. have craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
 - b. have a hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
4. Treatment related to hearing aids and implantable hearing devices covered under this subsection, including procedures for the implantation of implantable hearing devices.

Such hearing aids and implantable hearing devices must be prescribed by a physician or an audiologist in accordance with accepted professional medical or audiological standards.

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

Home Care Services

1. Covered Services.

This subsection applies only if charges for home care services are not covered elsewhere under the policy. We'll pay benefits for charges for the following home care services, subject to paragraph 2. below:

- a. part-time or intermittent home nursing care by or under supervision of a registered nurse;
- b. part-time or intermittent home health aide services that: (1) are part of the home care plan; (2) consist solely of care for the patient; and (3) are supervised by a registered nurse or medical social worker;
- c. physical or occupational therapy or speech-language pathology or respiratory care;
- d. medical supplies, drugs and medications prescribed by a physician; laboratory services by or on behalf of a hospital if needed under the home care plan. These items are covered to the extent they would be if you had been hospitalized;
- e. nutrition counseling provided or supervised by a registered or certified dietician; and
- f. evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. Your attending physician must request or approve this evaluation.

2. Limits on Home Care.

Home care is covered if ordered by a physician and determined by us to be medically necessary. We cover home safety evaluations, evaluations for a home treatment program, and/or initial visit(s) to evaluate you for an independent treatment plan. For all other home care to be determined medically necessary, you must be confined to your home due to an illness or injury or because leaving your home would be contraindicated. Examples of home care include, but are not limited to, IV administration, or wound care.

Benefits are limited to 60 home care visits per covered person per calendar year. Each visit by a person to provide services under a home care plan, or for evaluating your need, or for developing a home care plan counts as one home care visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.

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

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

Home Intravenous (IV) Therapy or Infusion Therapy

Intravenous (IV) therapy/infusion therapy performed in your home if prescribed by a physician. Home IV therapy or home infusion therapy includes, but is not limited to: (1) injections (intra-muscular, subcutaneous, continuous subcutaneous); (2) Total Parenteral Nutrition (TPN); and (3) antibiotic therapy.

Hospice Care

Hospice care services provided to you if you are terminally ill: (1) if your health condition would otherwise require your confinement in a hospital or a skilled nursing facility; and (2) hospice care is a cost-effective alternative, as determined by us.

Covered expenses for hospice care shall include:

1. Room and board at a hospice facility while you are receiving acute care to alleviate physical symptoms of your terminal illness;
2. Physician and nursing care; and
3. Services provided to you at your place of residence.

Room and board for residential care at a hospice facility is not covered.

We'll pay benefits for charges for covered expenses for hospice care services provided to you during the initial six-month period immediately following the diagnosis of a terminal illness. Coverage for hospice care services after the initial six-month period will be extended by us under the policy beyond the initial six month period; provided, a physician certifies in writing that you are terminally ill.

Hospital Services

Hospital services as shown below. This subsection does not include services for: (1) covered transplants; or (2) treatment of alcoholism, drug abuse or nervous or mental disorders, except for inpatient hospital services for detoxification of drug addiction or alcohol dependency. Please see subsections "Behavioral Health Services" and "Transplants."

1. Inpatient Hospital Services.

Benefits are payable for the following inpatient hospital services for a physical illness or injury:

- a. charges for room and board;
- b. charges for nursing services;
- c. charges for miscellaneous hospital expenses; and
- d. charges for intensive care unit room and board.

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

2. Outpatient Hospital Services.

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

3. Facility Fees.

Benefits are payable for facility fees charged by the hospital for office visits and for urgent care visits.

Kidney Disease Treatment

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

Kidney transplantation services are payable under the organ transplant benefit in subsection "Transplants."

Mastectomy Treatment

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

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Breast prostheses; and
4. Treatment of physical complications for all stages of mastectomy, including lymphedemas.

Maternity Services

Maternity services include:

1. Global maternity charge. The global maternity charge is a unique procedure billed by a physician that includes prenatal care, delivery, and one postpartum care visit. Examples of health care services for this procedure may include the prenatal physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis. Monthly visits up to 28 weeks, biweekly visits to 36 weeks, and weekly visits until delivery are included.
2. Hospital charges for vaginal or cesarean section delivery.
3. Exams and testing that are billed separately from the global maternity fee.
4. Health care services for miscarriages.
5. Health care services related to an abortion provided the abortion procedure for the termination of a mother's pregnancy is: (a) considered a life-threatening complication of the mother's existing physical illness; or (b) a result of rape or incest; and (c) the abortion procedure is permitted by, and performed in accordance with, law.

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

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

Medical Services

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

Telehealth shall be payable only if services are provided through a telehealth provider approved by us. For information about approved telehealth providers, visit www.WeCareForWisconsin.com or call the Customer Service telephone number shown on your identification card.

Medical Supplies

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

1. Strapping and crutches;
2. Initial pair of eyeglasses or external contact lenses: (a) for aphakia; (b) for keratoconus; and (c) following cataract surgery;
3. Elastic stockings or supports when prescribed by a physician and required in the treatment of an illness or injury. We may establish reasonable limits on the number of pairs allowed per covered person per calendar year;
4. Ostomy supplies limited to the following:
 - a. pouches, face plates and belts;
 - b. irrigation sleeves, bags and ostomy irrigation catheters;
 - c. skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above;

5. Enteral therapy (tube feeding) supplies if prescribed by a physician and determined by us as being appropriate for your medical condition. This does not include enteral formula, food, food supplements or vitamins; and
6. Disposable supplies, tubings and masks for the effective use of covered durable medical equipment.

Nutritional Counseling

Nutritional counseling that is: (1) for treatment of an illness or injury; and (2) provided by a physician, dietician or nutritionist licensed in the state where the counseling is provided to you. Nutritional counseling billed as educational services will not be covered.

Orthotic Devices and Appliances

Externally applied devices or appliances, including fittings and adjustments of custom-made rigid or semi-rigid supportive devices, that: (1) are used to support, align, prevent, or correct deformities; (2) improve the function of movable parts of the body; or (3) limit or stop motion of a weak or diseased body part.

Covered orthotic devices and appliances include, but are not limited to:

1. Casts and splints;
2. Orthopedic braces, including necessary adjustments to shoes to accommodate braces. Braces that straighten or change the shape of a body part are excluded from coverage;
3. Cervical collars;
4. Orthoses; and
5. Corsets (back and special surgical).

However, orthotic devices or appliances to support the foot are not covered unless they are a permanent part of an orthopedic leg brace.

Orthotic devices or appliances may be replaced once per calendar year per covered person when medically necessary. Additional replacements will be allowed: (1) if you are under age 18 due to rapid growth; or (2) when a device or appliance is damaged and cannot be repaired.

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

Pain Management Treatment

Pain management treatment including injections and other procedures to manage your pain related to an illness or injury. Pain management includes, but is not limited to, the following:

1. Medial branch neuroablation (denervation) of the facet joint nerves, limited to one treatment per calendar year regardless of location;
2. Facet joint injections and medial branch nerve blocks, limited to a maximum of four per calendar year regardless of location, type, or level;
3. Sacroiliac joint injections, limited to one per calendar year;
4. Artificial cervical disc replacement; and
5. Epidural injections, including selective nerve root blocks, limited to three injections per calendar year regardless of location, type or level.

Please note that many pain management services are considered experimental/investigational/unproven and therefore are not covered under the policy.

Pediatric Vision Services

Pediatric vision services as listed below for a covered person until the last day of the month in which he/she reaches age 19:

1. Routine eye exams.
2. Single vision, conventional (lined) bifocal, or conventional (lined) trifocal prescription lenses limited to one pair per covered person per calendar year. Lenses include the choice of glass, plastic, or polycarbonate and will include scratch resistant coating.
3. Frames from a selection of covered frames limited to one frame per covered person per calendar year. The health care provider will show you which frames are covered by the policy.
4. Contact lenses available from a selection of covered lenses when purchased in lieu of all other frames and/or lenses. Benefits are limited to six pairs of contact lenses every three months. The health care provider will show you which contact lenses are covered by the policy.

In addition, we'll pay benefits for charges for the following services, provided you receive our prior authorization:

1. Contact lenses for the following conditions:
 - a. pathological myopia;
 - b. anisometropia;
 - c. aniseikonia;
 - d. aniridia;
 - e. corneal disorders;
 - f. post-traumatic disorders; and
 - g. Irregular astigmatism.
2. Low vision services including the following:
 - a. one comprehensive low vision evaluation every five years;
 - b. low vision aids, limited to the following: (1) spectacles; (2) magnifiers; and (3) telescopes;
 - c. follow-up care of four visits in any five-year period.
3. The following lens options and treatments:
 - a. ultraviolet protective coating;
 - b. blended segment lenses;
 - c. intermediate vision lenses;
 - d. standard progressives;
 - e. premium progressives;
 - f. photochromic glass lenses;
 - g. plastic photosensitive lenses;
 - h. polarized lenses;

- i. standard anti-reflective coating;
- j. premium anti-reflective coating;
- k. ultra anti-reflective coating; and
- l. hi-index lenses.

Prescription Legend Drugs and Supplies

1. Definitions.

The following definitions apply to this subsection only:

Brand-Name Drug(s): a prescription legend drug sold by the pharmaceutical company or other legal entity holding the original United States patent for that prescription legend drug. For purposes of the policy, we may classify a brand-name drug as a generic drug if we determine that its price is comparable to the price of its generic equivalent.

Copayment: the amount you are required to pay for each prescription order or refill of a covered drug or covered supply. Your copayment amounts are shown in the Schedule of Benefits. You must pay this amount toward the purchase price charged by the provider for that covered drug or covered supply. The copayment applies to each separate prescription order or refill of a covered drug or covered supply. If the participating pharmacy's charge is less than the copayment, you will be responsible for the lesser amount.

Generic Drug(s): a prescription legend drug, whether identified by its chemical, proprietary, or non-proprietary name, that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA. For purposes of the policy, we may classify a generic drug as a brand-name drug if we determine that the generic drug's price is comparable to the price of its brand-name equivalent. The term generic drug shall also include over-the-counter drugs that we determine to be covered drugs.

Home Delivery: a participating pharmacy contracted with us or our delegate to dispense extended supplies of maintenance medications (typically greater than a 30-34 day supply).

Participating Pharmacy: a pharmacy that has contracted with us to be a participating pharmacy and that bills us directly for the charges you incur for covered drugs.

Preferred Drug(s): any generic or brand-name drug named on our list of preferred drugs which is available at www.WeCareForWisconsin.com . This list may change from time to time.

Prescription Legend Drug: any medicine, including investigational drugs used to treat the HIV virus as described in Wis. Stat. §632.895(9) whose label is required to contain the following wording: "Caution: Federal Law prohibits dispensing without prescription" or similar wording. Prescription legend drugs shall include insulin and other exceptions as designated by us.

Prescription Order: a written, electronic, or other lawful request for the preparation and administration of a prescription legend drug made by a physician or other provider with the authority to prescribe a drug for you.

Preventive Drugs: drugs that we are required by law to define as preventive drugs, including, but not limited to: (a) aspirin for the prevention of cardiovascular disease and after 12 weeks of gestation in women who are at high risk for preeclampsia; (b) fluoride supplements if you are older than six months; (c) iron supplement drops for asymptomatic children age 6-12 months; (d) folic acid for women planning or capable of pregnancy; (e) oral contraceptives, contraceptive patches, contraceptive devices (e.g., diaphragms, sponges, gel and female condoms) and contraceptive

vaginal rings for birth control; (f) nicotine replacements (e.g., patches and gum) and covered drugs used for smoking cessation if you are age 18 and over; (g) Vitamin D if you are age 65 and over and are at an increased risk for falls; (h) risk reducing medications, such as tamoxifen or raloxifene, for women who are at increased risk for breast cancer and at low risk for adverse medication effects; and (i) immunizations. For all preventive drugs, coverage is limited to: (a) generic drugs; and (b) brand-name drugs when there is no generic equivalent, unless the physician submits documentation to support the medical necessity of the use of a brand-name drug that has a generic equivalent. This definition of preventive drugs may change during the course of the year.

Specialty Drugs: prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost. To determine if a drug is a specialty drug and if that specialty drug requires our prior authorization, visit our website at www.WeCareForWisconsin.com or call the telephone number shown on your identification card.

Specialty Pharmacy: a pharmacy contracted with us or our delegate and designated by us to dispense specialty drugs. To inquire as to pharmacies that are currently participating as specialty pharmacies, you should contact us by calling the telephone number shown on your identification card.

2. Covered Drugs and Supplies.

We'll pay benefits as stated in the Schedule of Benefits for any of the following drugs, including refills, when they are medically necessary to treat your covered illness or injury and dispensed to you by a participating pharmacy:

- a. any prescription legend drug not otherwise excluded or otherwise limited under the policy;
- b. any medicine a participating pharmacy compounds as long as it contains at least one prescription legend drug that is not excluded under the policy, provided it is not considered experimental/investigative/unproven or not medically necessary;
- c. preventive drugs that can only be obtained from a pharmacy pursuant to a prescription order;
- d. specialty drugs;
- e. injectable insulin;
- f. prescription legend drugs that are FDA-approved for the treatment of HIV infection or an illness or medical condition arising from, or related to, HIV;
- g. an immunization that is not excluded elsewhere in the policy;
- h. oral chemotherapy drugs; and
- i. phase 3 experimental / investigational / unproven drugs that are FDA approved, administered according to protocol, and required by statute to be covered

We'll pay benefits as stated in the Schedule of Benefits for any of the following disposable diabetic supplies when they are medically necessary and dispensed to you by a participating pharmacy:

- a. insulin syringes and needles;
- b. lancets;
- c. diabetic test strips;

- d. alcohol pads;
- e. dextrose (tablets and gel);
- f. auto injector;
- g. auto blood sampler; and
- h. glucose control solution.

Our prior authorization is required for certain prescription drugs administered by a health care provider other than a pharmacy, including, but not limited to: (a) a physician's office; (b) the outpatient department of a hospital; (c) a dialysis facility; (d) a licensed skilled nursing facility; or (e) a home health agency. If you do not receive our authorization before receiving such drugs, benefits may not be payable under the policy. Even if we grant prior authorization, benefits for any specialty drug that is purchased from a provider other than a participating pharmacy shall be limited to what we would have paid if the specialty drug was purchased from a participating pharmacy. However, we may, at our discretion, allow initial doses(s) of a drug to be provided by a health care provider, other than a pharmacy, to allow you appropriate time to establish alternative sources. Initial doses approved by us shall not be limited to the amount we would have paid if the drug was purchased from a pharmacy.

Benefits are generally not payable for covered drugs and supplies dispensed by a non-participating pharmacy. We will, however, reimburse you for any covered drugs and supplies you receive during an emergency outside of the geographical service area. In this situation, you must pay for the covered drugs or supplies up front. Then you must send us a claim for reimbursement. Your claim must include written proof of payment and enough detail to allow us to process the claim. After we receive your claim and supporting documentation, we will determine if benefits are payable for the requested drug or supply. If so, we will pay you the benefit amount that we would have paid had you purchased the covered drug or supply from a participating pharmacy. You are liable for the copayment and any difference between our benefit payment and the price you paid for the covered drug or supply.

You will have no copayment for any preventive drug as defined in paragraph 1. above. All other covered drugs and supplies are subject to the copayment amounts listed in your Schedule of Benefits. If the participating pharmacy's charge is less than the copayment, you will only be responsible for the charge amount. Otherwise, you must pay the copayment amount for each separate prescription order or refill of a covered drug or covered supply.

We, at our sole discretion, may cover drugs or supplies that vary from the benefits described in the policy if there is an advantage to both you and us.

3. **Limitations.**

a. Limitations on Covered Drugs and Supplies Provided by a Pharmacy. No drug will be covered under the policy unless we determine that: you have a valid prescription order for the drug; the charge for the drug is equal to or more than the copayment for it; and the drug is not administered at the time and place of the provider dispensing it under the prescription order (except for immunizations). In addition, the following limitations apply to all prescription drug benefits provided by the policy:

(1) Covered Drugs or Supplies Available from a Home Delivery Pharmacy. If any covered drug is available through a home delivery pharmacy, we will only cover three fills at a retail pharmacy unless you have opted-out of the home delivery pharmacy program.

- (2) **Step Therapy.** If there is more than one prescription legend drug that has been determined to be safe and effective for the treatment of your illness or injury, we may only provide benefits for the less expensive prescription legend drug. Alternatively, we may require you to try the less expensive prescription legend drug(s) before benefits are payable for any other alternative prescription legend drug(s).
- (3) **Prior Authorization.** At our discretion, certain drugs, including all specialty drugs, require prior authorization from us before being eligible for coverage under the policy. To determine whether a drug requires our prior authorization, visit www.WeCareForWisconsin.com or call the telephone number shown on your identification card.

If a drug requires prior authorization, your provider must contact us or our designee to supply the information needed, such as copies of all corresponding medical records and reports for your illness or injury.

After receiving the required information, we (or our designee) will determine if the drug is covered under the policy and notify you of our coverage determination. If we determine that the treatment is not a covered drug, is not medically necessary, or is experimental / investigational / unproven, no benefits will be payable for that drug.

- (4) **Use of Brand-Name Drugs When Equivalent Generic Drugs Are Available.** If you obtain a brand-name drug and we determine that an equivalent generic drug is available, you must pay the difference in cost between the equivalent generic drug and the brand-name drug plus the brand-name drug copayment and/or deductible amount. Except as stated below, this limitation applies regardless of medical necessity or your physician's instructions, including any instruction that you use only the brand-name drug.

For preventive drugs as defined in paragraph 1. above, coverage is also generally limited to generic drugs when a generic equivalent is available. If, however, your physician submits proof to us that it is medically necessary for you to use a brand-name preventive drug instead of its generic equivalent, we will cover the brand-name preventive drug in full and you will not be charged. We will also cover a brand-name drug if substitution of an equivalent generic drug is prohibited by law.

- (5) **Quantity Limits.** The following quantity limits apply to all prescription legend drug benefits under this subsection. At our discretion, we may enforce additional quantity limits on specific drugs to ensure the appropriate amounts are dispensed. Please note that in certain circumstances, we may approve a partial amount (*i.e.* less than a 30-day supply) of a specialty drug until we (or our designee) determine you are tolerating the specialty drug. In this case, your financial responsibility will be prorated.

<i>Item</i>	<i>Quantity Limit</i>
Prescription Legend Drugs or Supplies Dispensed by a Pharmacy	30-day supply per fill or refill
Prescription Legend Drugs or Supplies, other than Specialty Drugs, dispensed by a Home Delivery Pharmacy	90-day supply per fill or refill

Covered Drugs used for Tobacco Cessation	180-day supply of nicotine replacement treatment (e.g., patches or gum) per covered person per calendar year; and 180-day supply of another type of covered tobacco cessation drug (e.g., varenicline or bupropion) per covered person per calendar year
Specialty drugs	30-day supply per fill or refill, except as noted above

(6) Miscellaneous. Age, gender or other edits may be enforced to ensure appropriate prescribing. Copayment or coinsurance applies to each cycle of hormone replacement therapy.

b. Limitations on Covered Drugs and Supplies Provided by a Provider Other than a Pharmacy. If we determine a prescription legend drug can safely be administered in a lower-cost place of service (including by self-administration), benefits for such prescription legend drugs shall be payable up to the amount we would have paid if the prescription legend drug was purchased from and administered by a provider in that lower-cost place of service (or self-administered). However we may, at our discretion, allow initial dose(s) of a drug to be administered by a health care provider in a higher-cost place of service to allow you appropriate time to establish alternative sources. Initial doses approved by us shall not be limited to the amount we would have paid if the drug was purchased and administered in the lower-cost place of service (including self-administration).

4. Exclusions.

The policy provides no benefits for any of the following:

- a. more than three fills of a maintenance medication, as determined by us, at a retail pharmacy, unless you have opted-out of the home delivery pharmacy program;
- b. administration of a covered drug by injection or other means other than covered immunizations;
- c. devices, appliances or durable equipment, except for covered supplies;
- d. refills of covered drugs that exceed the number the prescription order calls for;
- e. refills of covered drugs after one year from the date of the prescription order;
- f. covered drugs usually not charged for by the provider; or a covered drug for which the provider's actual charge billed for the covered drug is less than the copayment;
- g. covered drugs for which benefits are paid elsewhere under the policy;
- h. covered drugs completely administered at the time and place of the provider who dispenses the drugs under the prescription orders, except for immunizations and drugs for which you receive our prior authorization;
- i. anabolic steroids, unless we determine that they are being used for accepted medical purposes and eligible for coverage under the policy;
- j. progesterone or similar drugs in any compounded dosage form, except for the purpose of maintaining a pregnancy under the appropriate standard of care guidelines;
- k. costs related to the mailing, sending or delivery of prescription legend drugs;

- l.** prescription or refill of drugs, medicines, medications or supplies that are lost, stolen, spilled, spoiled, damaged, or otherwise rendered unusable;
- m.** any drug or medicine that is available in prescription strength without a prescription, except as determined by us;
- n.** more than one prescription for the same covered supply, covered drug or therapeutic equivalent medication prescribed by one or more providers until you have used at least 75% of the previous retail prescription. If the covered supply, drug or therapeutic equivalent medication is dispensed by a home delivery pharmacy, then you must have used at least 60% of the previous prescription;
- o.** charges properly covered by another insurance, government program, or manufacturer promotion (eg. coupon or rebate);
- p.** any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you;
- q.** any compounded drug that is substantially like a commercially available product;
- r.** any drug used for sexual dysfunction or to enhance sexual activity, regardless of why the drug is being prescribed to you;
- s.** any drug delivered to or received from a destination outside of the United States;
- t.** any drug for which prior authorization or step therapy is required, as determined by us, and not obtained;
- u.** drugs and medicines not covered under the policy. Please see section "EXCLUSIONS AND LIMITATIONS;" and
- v.** Drugs from a non-participating pharmacy, except for emergencies outside of the geographical service area.

Preventive Care Services

Preventive care services ordered by a physician. Covered preventive care services include:

- 1.** Routine immunizations including, but not limited to, those recommended by the Advisory Committee on Immunization Practices: influenza/flu, diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; haemophilus influenza B; meningitis, hepatitis A; hepatitis B; varicella; pneumococcal; meningococcal; rotavirus; human papillomavirus; and herpes zoster. Immunizations for travel purposes are not covered.
- 2.** Preventive services including, but not limited to, those recommended by the United States Preventive Services Task Force with an A or B rating:
 - a.** routine medical exams, including hearing exams, pelvic exams, pap smears, and any related routine diagnostic services, other than routine eye exams, mammograms and colorectal cancer screening. Pelvic exams and pap smears are covered under this paragraph when directly provided to you by a physician, certified nurse midwife or a nurse practitioner.
 - b.** routine medical exams, including hearing exams, and any related routine diagnostic services, other than routine eye exams, directly provided to a dependent child in connection with well-baby care. This includes those routine services directly provided by

a physician to a covered newborn child during the child's inpatient confinement following his/her birth (for example, circumcision).

- c.** one routine two dimensional mammogram of a female covered person per calendar year. Mammograms must be performed by or under the direction of a physician, certified nurse midwife or licensed nurse practitioner.
- d.** blood lead tests.
- e.** preventive screenings including, but not limited to:
 - (1)** screening for abdominal aortic aneurysm;
 - (2)** screening and behavioral counseling to reduce alcohol misuse, as determined by us;
 - (3)** screening for chlamydial infection;
 - (4)** screening for gonorrhea;
 - (5)** screening for congenital hypothyroidism in newborns;
 - (6)** screening for hearing loss in newborns;
 - (7)** screening for Hepatitis B and C;
 - (8)** screening for high blood pressure;
 - (9)** screening for HIV;
 - (10)** screening for iron deficiency anemia in asymptomatic pregnant women;
 - (11)** screening for lipid disorders;
 - (12)** screening for major depressive disorders in children and adolescents;
 - (13)** screening for phenylketonuria in newborns;
 - (14)** screening for RH incompatibility;
 - (15)** screening for osteoporosis;
 - (16)** screening for sickle cell disease in newborns;
 - (17)** screening for syphilis;
 - (18)** screening for type 2 diabetes;
 - (19)** screening for visual impairment in children under age five;
 - (20)** screening for depression in adults;
 - (21)** screening for bacteriuria;
 - (22)** screening for cervical cancer;
 - (23)** screening and behavioral counseling for obesity, as determined by us.

- (24) screening for gestational diabetes in pregnant women who are between 24 and 28 weeks of gestation and at the first prenatal visit if the woman is identified to be at high risk for diabetes;
 - (25) high risk human papillomavirus DNA testing in female covered persons with normal cytology results. Screening should begin at age 30 and should occur no more frequently than every three years;
 - (26) screening for lung cancer with low-dose computed tomography in adults aged 55 to 80 who have a 30 pack-year smoking history and currently smoke or have quit smoking within the last 15 years;
- f. behavioral interventions to promote breast feeding; comprehensive lactation support and counseling by a trained health care provider during pregnancy and/or in the postpartum period;
 - g. annual counseling on sexually transmitted infections;
 - h. counseling for tobacco use;
 - i. prophylactic ocular topical medication for newborns against gonococcal ophthalmia neonatorum;
 - j. annual screening and counseling for female covered persons for interpersonal and domestic violence;
 - k. healthy diet and physical activity counseling to prevent cardiovascular disease;
 - l. behavioral counseling for skin cancer.

Some laboratory and diagnostic studies may be subject to a deductible and/or coinsurance if determined not to be part of a routine preventive or screening examination. When you have a symptom or history of an illness or injury, laboratory and diagnostic studies related to that illness or injury are no longer considered part of a routine preventive or screening examination.

Prosthetics

Prosthetic devices and supplies, including the fitting of such devices, that replace all or part of: (1) an absent body part (including contiguous tissue); or (2) the function of a permanently inoperative or malfunctioning body part. Benefits are limited to one purchase no sooner than every three years of each type of the standard model, as determined by us. Prosthetic devices include, but are not limited to, artificial limbs, eyes, and larynx. We will also cover replacement or repairs if we determine that they are medically necessary. The policy does not cover dental prosthetics.

Pulmonary Rehabilitation

Benefits are payable for outpatient pulmonary rehabilitation therapy limited to 24 visits per covered illness per calendar year. No other benefits for outpatient pulmonary rehabilitation therapy are available under the policy.

Radiation Therapy and Chemotherapy Services

Radiation therapy and chemotherapy services. Benefits are also payable for charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in conjunction with radiation therapy and chemotherapy services.

Skilled Nursing Care in a Skilled Nursing Facility

Skilled nursing care you receive while confined in a skilled nursing facility if: (1) you are admitted to a skilled nursing facility within 24 hours after discharge from a hospital or ambulatory surgical center; and (2) you are admitted for continued treatment of the same illness or injury treated in the hospital.

We'll pay benefits for such skilled nursing care provided to you at that facility for up to 30 days of confinement. The 30-day limit stated in this subsection will be reduced by any charges for such days of confinement that are applied to the applicable deductible amounts.

*Benefits are payable only for the skilled nursing care that continues to treat the same illness or injury for which you were treated at the hospital prior to your admission to that skilled nursing facility. Benefits are only payable for skilled nursing care which is certified as medically necessary by your attending physician every seven days. If health care services can be provided at a lower level of care (e.g. home care or outpatient therapy), skilled nursing care during a skilled nursing facility confinement will not be covered.

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

Surgical Services

Surgical services stated below. This subsection does not include surgical services for: (1) covered transplants; (2) pain management procedures; or (3) behavioral health services. Please see subsections "Behavioral Health Services," "Transplants," and "Pain Management Treatment."

Covered surgical services include, but are not limited to:

1. Operative and cutting procedures;
2. Endoscopic examinations, such as: (a) arthroscopy; (b) bronchoscopy; or (c) laparoscopy; and
3. Other invasive procedures such as: (a) angiogram; (b) ateriogram; or (c) tap or puncture of brain or spine.

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

1. Surgical services, other than reconstructive surgery and oral surgery.
2. Reconstructive surgery for the treatment of the following:
 - a. a congenital illness or anomaly that results in a functional impairment;
 - b. an abnormality resulting from an injury; and
 - c. an abnormality resulting from infection or other disease of the involved body part, if such surgery occurs within 12 months of being diagnosed of the abnormality.
3. Oral surgery, including related consultation, x-rays and anesthesia, limited to the excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth. No other type of oral surgery is covered under the policy.
4. Sterilization procedures. Please note that reversal of a sterilization procedure is not covered under the policy.

5. Tissue transplants (e.g. arteries or veins, corneas, heart valves, skin) placed in the body to aid the function of a body organ or replace tissue lost due to illness or injury.

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

Temporomandibular Joint Disorders (TMJ)

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

1. The condition is caused by congenital, developmental or acquired deformity, disease or injury;
2. Under the accepted standards of the profession of the health care provider providing the service, the procedure is reasonable and appropriate for the diagnosis or treatment of the condition; and
3. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Non-surgical treatment includes coverage for prescribed intraoral splint therapy devices.

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

Therapy Services

Outpatient therapy, limited as follows:

1. Physical therapy and massage therapy limited to 20 visits per calendar year when billed as rehabilitative services and 20 visits per calendar year when billed as habilitative services. Massage therapy is covered only when the therapy is billed by a chiropractor, physical therapist or occupational therapist;
2. Speech therapy limited to 20 visits per calendar year when billed as rehabilitative services and 20 visits per calendar year when billed as habilitative services;
3. Occupational therapy limited to 20 visits per calendar year when billed as rehabilitative services and 20 visits per calendar year when billed as habilitative services; and
4. Respiratory therapy.

The visit limits stated above will be reduced by any charges for such visits that are applied to the applicable deductible amounts.

All therapy must be: (1) ordered by a physician prior to the commencement of therapy for treatment of a physical illness or injury; and (2) expected to provide significant measurable gains that will improve your physical health within 60 days of the date on which such therapy begins. The therapy must be performed by: (1) a physician; (2) a licensed physical, speech, occupational or respiratory therapist; or (3) any other

health care provider approved by us. The licensed therapist or other health care provider must be providing the therapy under the direction of your physician. If a license to perform such therapy is required by law, that therapist or other health care provider must: (1) be licensed by the state in which he/she is located; and (2) provide such therapy while he/she is acting within the lawful scope of his/her license. Physical therapy for your temporomandibular joint disorder is not covered under this paragraph.

Transplants

1. Definitions.

The following definitions apply to this subsection only:

Covered Transplant Drugs: immunosuppressant drugs prescribed by a physician when dispensed by a provider while you are not confined in a hospital. These drugs do not include high dose chemotherapy, except for high dose chemotherapy provided for a covered bone marrow transplant. This includes refills of immunosuppressant drugs.

Designated Transplant Facility: a facility that has agreed to provide approved transplant services to covered persons pursuant to an agreement with a transplant provider network with which we have a contract.

Non-Designated Transplant Facility: a facility that does not have an agreement with the transplant provider network with which we have a contract. This may include facilities that are listed as participating providers.

Organ and Tissue Acquisition: the harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to you. This includes related medical expenses of a living donor.

Transplant Services: approved health care services for which a prior authorization has been received and approved for transplants when ordered by a physician. Such services include, but are not limited to, hospital charges, physician's charges, organ and tissue procurement, tissue typing, and ancillary services.

2. Benefits.

All transplant services require prior authorization. If prior authorization is properly obtained, we'll pay benefits for charges for covered expenses you incur at a designated transplant facility as determined by us during the prior authorization process for an illness or injury. Transplant benefits are subject to any deductibles, coinsurance, maximum or limits shown in the Schedule of Benefits.

It is your responsibility to obtain a prior authorization for all transplant related services, including but not limited to the initial transplant evaluation. The transplant must meet our medical necessity criteria for such transplant and may not be experimental/investigational/unproven.

We will pay for approved transplant services, including but not limited to:

- a. organ and tissue acquisition and transplantation, including any post-transplant complications, if you are the recipient; or
- b. related medical care, including any post-harvesting complication, if you are a donor.

Covered expenses for transplant services include health care services for approved transplants when ordered by a physician. Health care services include, but are not limited to, hospital charges, physician charges, organ and tissue acquisition, tissue typing, and ancillary services.

Covered transplant drugs are payable as described in subsection "Prescription Legend Drugs and Supplies."

Benefits are payable for the following approved transplants:

- a. kidney;
- b. kidney/pancreas;
- c. liver;
- d. heart;
- e. heart/lung;
- f. lung;
- g. bone marrow (allogenic and autologous), when not considered to be experimental/investigational/unproven;
- h. stem cell transplants, when not considered to be experimental/investigational/unproven;
- i. small bowel transplantation; and
- j. cornea.
- k. any other transplant approved by us.

EXCLUSIONS AND LIMITATIONS

The policy provides no benefits for any of the following:

General Exclusions

- 1. Health care services that we determine are not medically necessary.
- 2. Health care services that we determine are experimental/investigational/unproven, except for investigational drugs used for the treatment of HIV infection as described in Wis. Stat. § 632.895 (9).
- 3. Health care services provided in connection with any injury or illness arising out of, or sustained in the course of, any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance. If you are covered by workers' compensation insurance, this exclusion applies regardless of whether benefits under worker's compensation laws or any similar laws have been claimed, paid, waived, or compromised.
- 4. Health care services furnished by the U.S. Veterans Administration, unless federal law designates the policy as the primary payer and the U.S. Veterans Administration as the secondary payer.
- 5. Health care services furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless such coverage under the policy is required by law.

6. Health care services covered by Medicare, if you have or are eligible for Medicare, to the extent benefits are or would be available from Medicare, except for such health care services for which under applicable federal law the policy is the primary payer and Medicare is the secondary payer. Please also see section "COVERAGE WITH MEDICARE."
7. Health care services for any illness or injury caused by any military-related act or incident of declared or undeclared war, riots, or insurrection.
8. Health care services for any illness or injury you sustain: (a) while on active duty in the armed services of any country; or (b) as a result of you being on active duty in the armed services of any country.
9. Custodial care or rest care.
10. Charges in excess of the maximum allowable fee or maximum out-of-network allowable fee.
11. General fitness programs, exercise programs, exercise equipment, and health club memberships.
12. Health care services for or related to gender reassignment surgery.
13. Health care services provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in custody of law enforcement officials, except as required under Wis. Stat. § 609.65. This exclusion does not apply to covered persons on work-release.
14. Completion of claim forms or forms necessary for the return to work or school.
15. An appointment you did not attend.
16. Telehealth, except as specifically stated in subsection "Medical Services."
17. Health care services for which you have no obligation to pay or which are provided to you at no cost.
18. Health care services resulting or arising from complications of, or incidental to, any health care service not covered under the policy, except for complications of, or services incidental to, a covered employee's or his/her spouse's elective abortion.
19. Health care services requested by a third party for employment, licensing, insurance, marriage, adoption, travel, disability determinations, or court-ordered exams, other than as specifically stated in the policy or required by law.
20. Cranial banding or orthotic helmets, unless required after cranial surgery.
21. Private duty nursing.
22. Marriage counseling.
23. Reversal of sterilization.
24. Transportation or other travel costs associated with a health care service, except as specifically provided in subsection "Ambulance Services."
25. Bereavement counseling, unless provided as part of hospice coverage.
26. Health care services that are excluded elsewhere in the policy.
27. Health care services not specifically identified as being covered under the policy, except for those health care services approved by us subject to subsection "Alternative Care."

- 28.** Health care services provided in connection with a health care service not covered under the policy (e.g., inpatient hospital services related to gastric bypass surgery).
- 29.** Health care services provided when your coverage was not effective under the policy. Please see section "WHEN COVERAGE ENDS."
- 30.** Health care services not provided by a physician or any of the health care providers listed in section "COVERED EXPENSES."
- 31.** The following procedures and any related health care services:
 - a.** injection of filling material (collagen) other than for incontinence;
 - b.** salabrasion;
 - c.** rhytidectomy (face lift);
 - d.** dermabrasion;
 - e.** chemical peel;
 - f.** suction-assisted lipectomy (liposuction);
 - g.** hair removal;
 - h.** mastopexy;
 - i.** mammoplasty, including augmentation or reduction mammoplasty (except for reconstruction associated with mastectomy);
 - j.** correction of inverted nipples;
 - k.** sclerotherapy for spider veins;
 - l.** panniculectomy;
 - m.** mastectomy for male gynecomastia;
 - n.** botulinum toxin or similar products, unless you receive our prior authorization;
 - o.** any modification to the anatomic structure of a body part that does not affect its function;
 - p.** labioplasty; and
 - q.** treatment of sialorrhea (drooling or excessive salivation).
- 32.** Health care services provided at any nursing facility or convalescent home or charges billed by any place that's primarily for rest, for the aged or for drug abuse or alcoholism treatment, except as specifically stated in subsection "Behavioral Health Services."
- 33.** Health care services provided: (a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting or trimming of toenails; or (c) in the non-operative partial removal of toenails. This exclusion does not apply to such health care services which are associated with a medical diagnosis of diabetes, peripheral vascular disease or peripheral neuropathy.

34. Health education; complementary, alternative or holistic medicine; or other programs with an objective to provide personal fulfillment.
35. Health care services that you receive not for the treatment of your own illness or injury, but in connection with the treatment of a collateral who is not a covered person under the policy.
36. Housekeeping, shopping, or meal preparation services.
37. Health care services provided in connection with: (a) any illness or injury caused by your engaging in an illegal occupation; or (b) any illness or injury caused by your commission of, or an attempt to commit, a felony.
38. Maintenance care or supportive care.
39. Health care services provided in connection with the temporomandibular joint or TMJ syndrome, except as specifically stated in subsection "Temporomandibular Joint Disorder (TMJ)."
40. Health care services for which proof of claim isn't provided to us in accordance with subsection "Filing Claims."
41. Health care services and prescription legend drugs provided in connection with alcoholism, drug abuse and nervous or mental disorders, except as specifically stated in the following subsections: (a) "Hospital Services" (limited to inpatient hospital services for detoxification of drug addiction or alcohol dependency); (b) "Behavioral Health Services;" (c) "Nutritional Counseling;" (d) "Prescription Legend Drugs and Supplies;" and (e) "Skilled Nursing Care in a Skilled Nursing Facility."
42. Health care services not for or related to an illness or injury, other than as specifically stated in the policy.
43. Sales tax or any other tax, levy, or assessment by any federal or state agency or a local political subdivision.
44. Costs associated with indirect services provided by health care providers such as: creating standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; reviewing quality assurance data; transporting lab specimens; physician concierge payments; translating claim forms or other records; and after-hours charges.
45. Treatment of weak, strained, flat, unstable or unbalanced feet; arch supports; heel wedges; lifts; orthopedic shoes; or the fitting of orthotics to aid walking or running; unless specifically stated otherwise in the policy.
46. Health care services for treatment of sexual dysfunction, including impotence, regardless of the cause of the dysfunction. This includes: (a) surgical services; (b) devices; (c) drugs for, or used in connection with, sexual dysfunction; (d) penile implants; (e) sex therapy; and (f) the treatment of Peyronie's disease.
47. Health care services not supported by information contained in your medical records or from other relevant sources.
48. Health care services provided for your convenience or for the convenience of a physician, hospital, or other health care provider.
49. Baseline neuropsychological testing, for example, impact testing.
50. Magnetic sphincter augmentation (Linx® System); transoral incisionless fundoplication procedures.

51. Health care services that are for purposes of educational, occupational or athletic enhancement.
52. Storage of blood tissue, cells, or any other body fluids.
53. Salivary hormone testing.
54. Non-emergency health care services performed while outside of the United States.
55. Prolotherapy.
56. Platelet-rich plasma.
57. Coma stimulation programs.
58. In lab polysomnogram (PSG), unless a home sleep study is determined by us to not be medically appropriate.

Cosmetic Treatment Exclusion

Health care services that we determine to be cosmetic treatment.

Dental Services Exclusions

1. The care and treatment of teeth, gums, or alveolar process including dentures, appliances, or supplies used in such care or treatment.
2. Injuries or damage to teeth (natural or otherwise) that result from or are caused by the chewing of food or similar substances.
3. Dental implants or other implant related procedures, except as specifically stated in subsection "Dental Services."
4. Orthognathic surgery or any surgical procedure performed to correct deformities of the mandible or maxilla, correction of malocclusion, or orthodontic treatment (e.g. braces), except as specifically stated in subsection "Dental Services."
5. Tooth extraction of any kind, except as specifically stated in subsection "Dental Services."

Drug Exclusions

1. Non-legend vitamins, minerals, and supplements even if prescribed by a physician, except as specifically stated in subsection "Prescription Legend Drugs."
2. All enteral feedings, supplemental feedings, over-the-counter nutritional and electrolyte supplements, including infant formula.
3. Retinoids, Minoxidil, Rogaine, or their medical equivalent in the topical application form.
4. Medications, drugs, or hormones to stimulate human biological growth, unless there is a laboratory-confirmed physician's diagnosis of your growth hormone deficiency.

Durable Medical Equipment, Medical Supplies and Prosthesis Exclusions

1. Modifications to your vehicle, home or property including, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, chair lifts, grab bars, raised toilet seats, commodes, or ramps.
2. Medical supplies and durable medical equipment for your comfort, personal hygiene, or convenience including, but not limited to, physical fitness equipment, physician's equipment, disposable supplies (other than colostomy supplies, enteral therapy supplies and/or urinary catheters and supplies), or self-help devices not medical in nature.
3. Environmental items including, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.
4. Wigs, toupees, hairpieces, cranial prosthesis, hair implants, or transplants or hair weaving.
5. Replacement of batteries and routine periodic maintenance of durable medical equipment, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of one month rental billed every six months.
6. Rental fees for durable medical equipment that are more than the purchase price.
7. Durable medical equipment or prosthetics that we determine to have special features.
8. Continuous passive motion (CPM) devices and mechanical stretching devices.
9. Repairs due to abuse or misuse.
10. Home devices such as:
 - a. home spinal traction devices or standers;
 - b. home INR (international normalized ration blood test) monitors;
 - c. home phototherapy for dermatological conditions;
 - d. home pneumatic compression devices for DVT (deep vein thrombosis) prevention;
 - e. cold therapy (application of low temperatures for the skin) including, but not limited to, cold packs, ice packs, cryotherapy.
11. Light boxes for behavioral health conditions.
12. Car seats.

Genetic Counseling, Studies, and Testing Exclusions

1. Genetic counseling, studies and testing other than the coverage that is specifically provided in subsection "Genetic Services."
2. Genetic testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone.
3. Genetic testing for conditions which cannot be altered by treatment or prevented by specific interventions.

4. Genetic testing solely for the purpose of informing the care or management of your family members.
5. Genetic counseling performed by the laboratory that performed the genetic test.

Hearing Services Exclusions

1. Augmentation communication devices and related instruction or therapy.
2. Hearing protection equipment.

Hospital Services Exclusion

Hospital stays if care could be provided in a less acute setting.

Infertility Exclusions

1. Health care services associated with expenses for infertility or fertility treatment, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to health care services required to treat or correct underlying causes of infertility.
2. Direct attempts to achieve pregnancy or increase chances of achieving pregnancy by any means.
3. Evaluation and treatment of habitual abortions (three consecutive documented spontaneous abortions in the first or second trimesters) when not pregnant.
4. Any laparoscopic procedure during which an ovum is manipulated for the purpose of fertility treatment even if the laparoscopic procedure includes other purposes.

Maternity Exclusions

1. Birthing classes, including Lamaze classes.
2. Abortion procedures, except as specifically stated in subsection "Maternity Services."
3. Home births.

Reconstructive Surgery Exclusions

Reconstructive surgery, except as stated in subsection "Surgical Services."

Rehabilitation/Rehabilitative Services Exclusions

1. Vocational or industrial rehabilitation including work hardening programs.
2. Cardiac rehabilitation beyond Phase II.
3. Sports hardening and rehabilitation.
4. Health care services used in educational or vocational training or testing.

5. Health clubs or health spas, aerobic and strength conditioning, functional capacity exams, physical performance testing, and all related material and products for these programs.
6. Long-term therapy and maintenance therapy.

Therapy Exclusions

1. Massage therapy or aquatic therapy, except as specifically stated in subsection "Therapy Services."
2. Hypnosis.
3. Sex therapy.
4. Chelation therapy, except in the treatment of heavy metal poisoning.
5. Health care services for holistic or homeopathic medicine or other programs that are not accepted medical practice, as determined by us, including, but not limited to, aromatherapy, herbal medicine, naturopathy, and reflexology.
6. Biofeedback, except for fecal/urinary incontinence.
7. Health care services by an athletic trainer.
8. Therapy services such as recreational therapy (other than recreational therapy included as part of a treatment program received during an inpatient hospital confinement for treatment of nervous or mental disorders, alcoholism or drug abuse), educational therapy, physical fitness, or exercise programs, except as specifically stated in subsection "Cardiac Rehabilitation Services" and "Therapy Services."
9. Photodynamic therapy and laser therapy for the treatment of acne.
10. Acupuncture therapy.

Transplant Exclusions

1. Transplants considered by us to be experimental, investigational, or unproven.
2. Expenses related to the purchase of any organ.
3. Health care services for, or used in connection with, transplants of human and non-human body parts, tissues or substances, implants of artificial or natural organs or any complications of such transplants or implants, except as specifically stated in subsection "Transplants."
4. Lodging expenses, including meals, unless such expenses are covered under the global fee agreement of your transplant network.

Vision Services Exclusions

1. Vision therapy;
2. Orthoptic therapy and pleoptic therapy (eye exercise);

3. Preparation, fitting or purchase of eye glasses or contact lenses, except as specifically stated in the policy;
4. Correction of visual acuity or refractive errors by any means, except as specifically stated in the policy;
5. Implantable accommodating lenses to improve vision following cataract surgery;
6. Replacement lenses, frames, or contact lenses due to loss, theft, or damage; and
7. Routine eye exams, except as specifically stated in the policy.

Weight Control Exclusions

Health care services provided in connection with a diagnosis of obesity, morbid obesity, weight control, or weight reduction, regardless of whether such services are prescribed by a physician or associated with an illness or injury. Services excluded under this provision include, but are not limited to:

1. Gastric or intestinal bypasses;
2. Gastric balloons or banding;
3. Stomach stapling;
4. Wiring of the jaw;
5. Liposuction;
6. Drugs;
7. Weight loss programs, unless benefits are provided elsewhere in the policy;
8. Physical fitness or exercise programs or equipment, unless benefits are provided elsewhere in the policy; and
9. Bone densitometry (DEXA, DXA) scans.

Preventive/Wellness Care Exclusions

Immunizations for travel purposes.

COORDINATION OF BENEFITS (COB)

Applicability

1. This section applies when you have health care coverage under more than one plan. "Plan" and "this plan" are defined below.
2. If this section applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

- a. shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but
- b. may be reduced when, under the order of benefit determination rules, another plan determines its benefits first. This reduction is described in subsection "Effect on the Benefits of This Plan."

Definitions

The following definitions apply to this section only:

1. **Allowable Expense:** a health care service or expense, including deductibles and copayments, that is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided shall be considered both an allowable expense and a benefit paid.
2. **Claim Determination Period:** a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this section or a similar provision takes effect.
3. **Custodial Parent:** a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
4. **Plan:** any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
 - a. Individual or group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - b. Coverage under a governmental plan or coverage that is required or provided by law. . It does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
 - c. Medical expense benefits coverage in group, group-type and individual automobile "no-fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis are included.

Each contract or other arrangement for coverage under a., b. or c. above is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

5. **Primary Plan/Secondary Plan:** Subsection "Order of Benefit Determination Rules" states whether this plan is a primary plan or secondary plan as to another plan covering the person.

When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans and may be a secondary plan as to a different plan or plans.

6. **This Plan:** the part of the policy that provides benefits for health care expenses.

Order of Benefit Determination Rules

1. General.

When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:

- a. the other plan is automobile medical expense benefit coverage or has rules coordinating its benefits with those of this plan; and
- b. both those rules and this plan's rules described in 2. below require that this plan's benefits be determined before those of the other plan.

2. Rules.

This plan determines its order of benefits using the first of the following rules which applies:

- a. **Non-dependent/Dependent.** The benefits of the plan which covers the person as an employee, member or subscriber are determined before those of the plan which covers the person as a dependent of an employee, member or subscriber.
- b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in 2. c. below, when this plan and another plan cover the same child as a dependent of different persons, called "parents":
 - (1) the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but
 - (2) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (1) but instead has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits.

- c. **Dependent Child/Separated or Divorced Parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (1) first, the plan of the parent with custody of the child;
 - (2) then, the plan of the spouse of the parent with custody of the child; and
 - (3) finally, the plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to 2. b. above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. Active/Inactive Employee.** The benefits of a plan which covers a person as an employee who is neither laid-off nor retired or as that employee's dependent are determined before those of a plan which covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule d. is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this paragraph d.
- e. Continuation Coverage.**

 - (1)** If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

 - (a)** first, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber;
 - (b)** second, the benefits under the continuation coverage.
 - (2)** If the other plan does not have the rule described in subparagraph (1), and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.
- f. Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.
- g.** If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of This Plan

1. When This Subsection Applies.

This subsection applies when, in accordance with subsection "Order of Benefit Determination Rules," this plan is a secondary plan as to one or more other plans. In that event the benefits of this plan may be reduced under this subsection. Such other plan or plans are referred to as "the other plans" in 2. below.

2. Reduction in This Plan's Benefits.

The benefits of this plan will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

- a.** the benefits that would be payable for the allowable expenses under this plan in the absence of this section; and

- b. the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this section, whether or not claim is made. Under this provision, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

Right to Receive and Release Needed Information

We have the right to decide which facts we need to apply these COB rules. We may get needed facts from or give them to any other organization or person without your consent but only as needed to apply these COB rules. Medical records remain confidential as provided by law. Each person claiming benefits under this plan must give us any facts we need to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this section, we may recover the excess from one or more of:

1. The persons we paid or for whom we paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coverage with Medicare

The policy will coordinate benefits with Medicare in accordance with federal law.

A covered person who is eligible for Medicare is considered enrolled in and covered under Medicare Parts A and B, whether or not he/she is actually enrolled in one or both parts of Medicare. The policy will coordinate benefits as if you were covered by Medicare. For example, if you are eligible to enroll in Medicare Part B but fail to do so, we will still determine benefits that are payable under the policy as if you had Medicare Part B coverage and Medicare paid Part B benefits, even if Medicare didn't pay any Part B benefits. You will be responsible for all covered expenses that would have been covered by Medicare.

WHEN COVERAGE ENDS

General Rules

We may terminate your coverage under the policy on the earliest of the following dates:

1. The date the policy terminates.
2. The day immediately following the date you die.
3. The day immediately following the last day of the applicable grace period if the premium required for your coverage has not been paid to us in accordance with the policy.
4. The date you enter into military service, other than for duty of less than 30 days.
5. The day immediately following the last day of the calendar month in which the covered employee's employment terminates.
6. The day immediately following the last day of the calendar month in which we determine the covered employee is not within the class of employees eligible for coverage under the policy or is not actively at work. However, the employee's coverage under the policy may continue if:
 - a. he/she is granted an approved leave of absence protected by the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), or any workers' compensation leave of absence. In this case, the covered employee's coverage will continue until the day immediately following the last day of the calendar month in which we determine the covered employee fails to return to work from that leave of absence;
 - b. he/she is granted a leave of absence under the policyholder's established leave of absence policy. In this case, the covered employee's coverage will continue no longer than three consecutive months following the date on which his/her coverage would have otherwise ended, unless a later date is specifically stated in the employer's leave of absence policy. Such leave of absence policy and any supporting documentation must be provided to us upon our request;
 - c. the covered employee is subject to a collective bargaining agreement. In this case, the covered employee's coverage will continue as stated in that agreement if that agreement has termination dates other than as stated in a. or b. above. Such collective bargaining agreement and any supporting documentation must be provided to us upon our request.

The policyholder must continue to pay the required premiums during any period of continued coverage stated in this paragraph 6.

7. The day immediately following the last day of the calendar month in which a covered employee requests that his/her coverage terminate under the policy.
8. For a covered employee's covered dependent, the date the covered employee's coverage terminates.
9. For a covered employee's spouse or domestic partner who is a covered person: (a) the day immediately following the date the covered employee's spouse is no longer married to the covered employee due to divorce or annulment; or (b) the day immediately following the date the domestic partner no longer meets the requirements stated in the definition of "dependent."
10. For a child who is a covered dependent, the earliest of the following dates, as determined by us:

- a. the day immediately following the last day of the calendar month in which the child reaches age 26, unless he/she is a full-time student returning from military duty or a disabled dependent as defined in the policy;
- b. for step-children, the date the covered employee's spouse is no longer married to the covered employee.

A full-time student who attains the limiting age while covered under the policy will remain eligible for benefits until the day immediately following the last day of the calendar month in which the child ceases to be a full-time student as defined in the policy.

11. For a child of a covered dependent child, the date the dependent child reaches age 18.

It is the covered employee's responsibility to notify us of his/her child losing dependent status. If he/she does not so notify us, the covered employee shall be responsible for any claim payments made during the period of time the dependent was not eligible for coverage under the policy.

Special Rules for Full-Time Students Returning from Military Duty

A full-time student returning from military duty may continue coverage if he/she ceases to be a full-time student due to a medically necessary leave of absence. In order to continue coverage, we must receive written documentation and certification of the medical necessity of the leave of absence from his/her attending physician. The date on which he/she ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which coverage continuation begins.

Coverage shall continue for a full-time student returning from military duty on a medically necessary leave of absence until the earliest of the following dates:

1. He/she advises us that he/she does not intend to return to school full-time;
2. He/she becomes employed full time;
3. He/she obtains other health care coverage;
4. He/she marries and is eligible for coverage under his/her spouse's health coverage;
5. The date coverage of the subscriber through whom he/she has dependent coverage under the policy is discontinued or not renewed; or
6. One year following the date his/her continuation coverage began and he/she has not returned to school on a full-time basis.

It is the covered employee's responsibility to notify us of his/her child losing dependent status. If he/she does not so notify us, the covered employee shall be responsible for any claim payments made on behalf of the child while he/she was not eligible for coverage under the policy.

Special Rules for Disabled Children

If you have family coverage under the policy, a child who is: (1) incapable of self-sustaining employment because of intellectual disability or physical impairment; and (2) chiefly dependent upon the covered employee for support and maintenance, may continue coverage under your family coverage beyond the limiting age as set forth in the definition of dependent.

Written proof of a child's disability must be given to us within 31 days after the child turns age 26. Failure to provide such proof within that 31-day period shall result in the termination of that child's coverage. After the child turns 28, we may request proof of disability annually.

It is the covered employee's responsibility to notify us of his/her child no longer qualifies as a dependent due to his/her intellectual disability or physical impairment. If he/she does not so notify us, the covered employee shall be responsible for any claim payments made on behalf of the child during the period of time he/she was not eligible for coverage under the policy.

Extension of Benefits

This subsection only applies when (1) the policy is not replaced by another group health insurance policy, group health plan, or self-insured group health benefits plan; and (2) we determine that we determine that Wis. Admin. Code §§ Ins 6.51 (6) and (7) require that we provide an extension of coverage.

On the date the policy ends for all covered persons, benefits will continue for each covered person who, on the date the policy ends, is:

1. Totally disabled; or
2. Confined in a hospital.

An extension of benefits provided under this subsection shall end on the earliest of the following dates:

1. The day you are no longer totally disabled or no longer confined in a hospital;
2. The day on which 12 consecutive months have passed since the date the policy ended; or
3. The day on which coverage for the condition(s) causing your total disability or confinement is provided under similar coverage, other than temporary coverage required by Wis. Admin. Code § Ins 6.51 (7m) (b) under another group health plan.

This extension of benefits doesn't provide coverage for dental services, uncomplicated pregnancies or for any injury or illness other than the covered illness or injury causing the covered employee's total disability, the dependent's confinement, or the dependent's total disability.

Disenrollment from the Plan

Disenrollment means that your coverage under the policy is revoked. We may disenroll you only for the reasons listed below:

1. Required premiums are not paid by the end of the grace period;
2. You allow a non-covered person to use your identification card to obtain health care services; or
3. You have performed an act or practice that constitutes fraud or made an intentional material misrepresentation of material fact under the terms of the coverage.

CONTINUATION COVERAGE PRIVILEGE

Wisconsin Law

In certain cases you may be eligible to continue coverage that would otherwise end under section "WHEN COVERAGE ENDS" in accordance with Wis. Stat. § 632.897. Those who are eligible to purchase continuation coverage are: (1) covered employees who are no longer eligible for coverage under the policy through the policyholder, except if their employment is terminated for misconduct; or (2) a covered employee's spouse or dependent who is no longer eligible for coverage under the policy through the policyholder due to divorce, annulment or death of the covered employee. In either case, you must be covered under the policy through the policyholder for at least three consecutive months immediately prior to the termination date of your coverage in order to qualify for continuation coverage.

Within five days of the policyholder's receiving notice to end your coverage or notice that you are eligible under (1) or (2) above, the policyholder must notify you of:

1. Your option to continue your coverage under this subsection;
2. The monthly premium amount you must pay to continue your coverage. The premium amount for continuation coverage will be at the premium rate that we require for such coverage;
3. The manner in which and the place to which you must make premium payments; and
4. The time by which you must pay the premiums required for continuation coverage.

If you are eligible to purchase continuation coverage under Wis. Stat. § 632.897 and timely elect to continue your coverage and pay to the policyholder the required premium within 30 days after receiving the notice described above from the policyholder, the policyholder must notify us of your election of continuation coverage as soon as reasonably possible in the manner required by us. Your continuation coverage under the policy may be continued until the earliest of the following dates:

1. The date you become eligible for other similar group health care coverage or the same coverage under the policy;
2. For a covered employee's spouse, the date the covered employee is no longer eligible for coverage under the policy;
3. The date the policy terminates;
4. The date you move out of Wisconsin;
5. The end of the last coverage period for which you paid the required premium; or
6. 18 consecutive months after you elect continuation coverage.

If any of the six events described above applies to a covered person with continuation coverage, the covered person whose continuation coverage terminated under the policy due to that event must give written notice of that event to the policyholder and us as soon as reasonably possible. The policyholder must also notify us of that event as soon as reasonably possible after becoming aware of that event.

The continuation coverage described above is made available by us only to the limited extent that we're required to provide such coverage under Wis. Stat. § 632.897. Nothing in this section provides, or shall be interpreted or construed to provide, any coverage in excess of, or in addition to, the continuation coverage required to be provided by us under Wis. Stat. § 632.897.

Federal Law

A covered person who is no longer eligible for coverage under the policy, such as a covered person whose employment ends with the policyholder, certain dependent children, or a divorced or surviving spouse and his/her children, may be eligible to purchase continuation coverage under the policy in accordance with the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as amended.

You must contact the policyholder within 60 days of a divorce or a child losing dependent status under the policy in order to be eligible for COBRA continuation. You have 60 days following the termination date to elect to continue coverage under COBRA.

If you are eligible to purchase continuation coverage under COBRA, please see the policyholder for further information.

COVERAGE WITH MEDICARE

If covered charges are incurred by a covered person who is a Medicare beneficiary, we will determine the benefits payable under the policy using the following rules. The rules require Medicare to pay as the secondary payer (and the employer group health plan to pay as the primary payer) when:

1. The covered person (employee or the employee's spouse) is age 65 or older and is covered under an employer group health plan of an employer that employs at least 20 persons (including part time employees) for a minimum of 20 weeks during the current or preceding calendar year and has not elected to have Medicare as the sole source of medical protection.
2. The covered person is under age 65, is covered under an employer group health plan of an employer of at least 100 employees, as a result of the covered person's current employment status or that of a covered family member, and is receiving Medicare benefits due to a permanent and total disability. In this case, the employer must have at least 100 people actively employed 50 percent or more of the regular business days in the preceding calendar year.

A person with "current employment status" is an individual who is working as an employee, is the employer (including self-employed persons) or is an individual associated with the employer in a business relationship.

3. A covered person is covered under an employer group health plan, and has end-stage renal disease (ESRD). If an ESRD patient has health insurance coverage under an employer group health plan, Medicare is secondary for 30 months from entitlement to, or eligibility for, Medicare Part A based on ESRD.

GENERAL PROVISIONS

Your Relationship with Your Physician, Hospital or Other Health Care Provider

We won't interfere with the professional relationship you have with your physician, hospital or other health care provider. We do not require that you choose any particular physician, hospital, or other health care provider, although there may be different benefits payable under the policy depending on your choice of physician, hospital, or other health care provider. We do not guarantee the competence of any particular physician, hospital, other health care provider, nor can we guarantee their availability to provide services to you. You must choose the physician, hospital, or other health care provider you would like to see and

you also must choose what health care services you wish to receive. We're not responsible for any injury, damage or expense (including attorneys' fees) you suffer as a result of any improper advice, action or omission on the part of any physician, hospital, or other health care provider, including, but not limited to, any participating provider. We're obligated only to provide the benefits as specifically stated in the policy.

Physician, Hospital or Other Health Care Provider Reports

Physicians, hospitals and other health care providers must release medical records and other claim-related information to us so that we can determine what benefits are payable to you. By accepting coverage under the policy, you authorize and direct the following individuals and entities to release such medical records and information to us, as required by a particular situation and allowed by applicable laws:

1. Any physician who has diagnosed for, attended, treated, advised or provided health care services to you;
2. Any hospital in which you were treated or diagnosed;
3. Any other health care provider who has diagnosed, attended, treated, advised or provided services to you; and
4. Any other insurance company, service, or benefit plan that possesses information that we need to determine your benefits under the policy.

This is a condition of our providing coverage to you. It's also a continuing condition of our paying benefits.

Assignment of Benefits

This coverage is just for a covered employee and his/her covered dependents. Benefits may be assigned to the extent allowed by the Wisconsin insurance laws and regulations.

Subrogation

We have the right to subrogate against a third party or to seek reimbursement from you for the medical expenses necessarily incurred by you and related to an illness or injury caused by a third party. When you receive a benefit under the policy for an illness or injury, we are subrogated to your right to recover the reasonable value of the services provided for your illness or injury to the extent of the benefits we have provided under the policy.

Our subrogation rights include the right of recovery for any injury or illness a third party caused or is liable for. "Third party" claims are claims against any insurance company or any person or party that is in any way responsible for providing payment as a result of the illness or injury. These rights also include the right of recovery under uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, and any other applicable insurance. We may pursue our rights of subrogation against any party liable for your illness or injury or any party that has contracted to pay for your illness or injury. In the event you have or may recover for your injury, we have the right to seek reimbursement from you for the actual cash value of any payments made by us to treat such illness or injury.

You or your attorney or other representative agree to cooperate with us in pursuit of these rights and shall:

1. Sign and deliver all necessary papers we reasonably request to protect or enforce our rights;
2. Do whatever else is necessary to protect or allow us to enforce our rights including joining us as a party as we may request when you have commenced a legal action to recover for a personal injury; and

3. Shall not do anything before or after our payment that would prejudice our rights.

Our right to subrogate shall not apply unless you have been made whole for loss of payments which you or any other person or organization is entitled to on account of illness or injury. You agree that you have been made whole by any settlement where your claim has been reduced because of your contributory negligence. You also agree that you have been made whole if you receive a settlement for less than the third party's insurance company's policy limits. If a dispute arises over the question of whether or not you have been made whole, we reserve the right to seek a judicial determination of whether or not you have been made whole.

We will not pay fees or costs associated with any claim or lawsuit without our express written consent. We reserve the right to independently pursue and recover paid benefits.

Limitation on Lawsuits and Legal Proceedings

By accepting coverage under the policy, you agree that you will not bring any legal action against us regarding benefits, claims submitted, the payment of benefits or any other matter concerning your coverage until the earlier of: (1) 60 days after we've received or waived the proof of claim described in subsection "Filing Claims" below; or (2) the date we deny payment of benefits for a claim. This provision does not apply if waiting will result in prejudice against you. However, the mere fact that you must wait until the earlier of the above dates does not alone constitute loss or injury.

By accepting coverage under the policy, you also agree that you will not bring any legal action against us more than three years after the time we require written proof of claim. Please see subsection "Filing Claims" below.

Severability

Any term, condition or provision of the policy that is prohibited by Wisconsin law shall be void and without force or effect. This, however, won't affect the validity and enforceability of any other remaining term, condition or provision of the policy. Such remaining terms, conditions or provisions shall be interpreted in a way that achieves the original intent of the parties as closely as possible.

Filing Claims

1. How to File a Claim.

After health care services are provided to you, either you or your health care provider must submit a claim to us in accordance with this subsection. The following information must be filed with us within 90 days after receiving a health care service:

- a. claim forms (including the proper code for each health care service, date of each health care service, name of the health care provider, place of service and billed charges) received from the health care provider at the time of the health care service; and
- b. proof of payment.

If you receive health care services in a country other than the United States, you will need to pay for the health care services upfront and then submit the claim to us for reimbursement. We will reimburse you for any covered expenses in U.S. currency. The reimbursement amount will be based on the U.S. equivalency rate that is in effect on the date you paid the claim or on the date of service if the date of payment is unknown.

2. Time Limit on Filing Claims.

If you do not file the required information within 90 days after receiving a health care service, benefits will be paid for covered expenses if:

- a. it was not reasonably possible to provide the required information within such time; and
- b. the required information is furnished as soon as possible and no later than one year following the initial 90-day period. The only exception to this rule is if you are legally incapacitated. If we do not receive written proof of claim required by us within that one-year and 90-day period and you are not legally incapacitated, no benefits are payable for that health care service under the policy.

3. How to Appeal a Claim Denial.

If a claim is denied, you may appeal the denial by filing a written grievance. Please refer to subsection "Our Internal Grievance Procedure" for more information.

Conformity with Applicable Laws and Regulations

On the effective date of the policy, any term, condition or provision that conflicts with any applicable laws and regulations shall automatically conform to the minimum requirements of such laws and regulations.

Entire Contract

The entire contract between you and us is made up of the policy, including the policyholder's group application, the policyholder's supplemental applications, if any, the certificate, Schedule of Benefits, any endorsements, your application, and any supplemental applications.

Waiver and Change

Only our Chief Executive Officer can execute a waiver or make a change to the policy. No agent, broker or other person may waive or change any term, condition, exclusion, limitation, or other provision of the policy in any way or extend the time for any premium payment. We may unilaterally change any provision of the policy if we send written notice to the policyholder at least 30 days in advance of that change. When the change reduces coverage provided under the policy, we must send written notice of the change to the policyholder at least 60 days before any such change takes effect.

Any change to the policy shall be made by an endorsement signed by our Chief Executive Officer. Each endorsement shall be binding on the policyholder, all covered persons, and us. No error by us, the policyholder, or any covered person shall: (1) invalidate coverage otherwise validly in force; (2) continue or reissue coverage validly terminated; or (3) cause us to issue coverage that otherwise would not be issued. If we discover any error, we may, at our sole discretion, make an equitable adjustment of coverage, payment of benefits, and/or premium.

Direct Payments and Recovery

1. Direct Payment of Benefits.

Unless otherwise specifically stated in the policy, we have the option of paying benefits either directly to the physician, hospital or other health care provider, or to you as described below in subsection "Claims Processing Procedure." Payments for covered expenses for which we're liable may be paid under another group or franchise plan or policy arranged through your employer, trustee, union or association. If so, we can discharge our liability by paying the organization that

has made these payments. In either case, such payments shall fully discharge us from all further liability to the extent of benefits paid.

2. Recovery of Excess Payments.

If we pay more benefits than what we're liable to pay for under the policy, including, but not limited to, benefits paid in error by us, we can recover the excess benefit payments from any person, organization, physician, hospital or other health care provider that has received such excess benefit payments. We can also recover such excess benefit payments from any other insurance company, service plan or benefit plan that has received such excess benefit payments. If we cannot recover such excess benefit payments from any other source, we can also recover such excess benefit payments from you. When we request that you pay us an amount of the excess benefit payments, you agree to pay us such amount immediately upon our notification to you. We may, at our option, reduce any future benefit payments for which we are liable under the policy on other claims by the amount of the excess benefit payments, in order to recover such payments. We will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by us.

Quality Improvement

The Arise Health Plan Quality Improvement Committee evaluates and monitors key aspects of service and health care provided to covered persons. The medical director directs the Quality Improvement Committee. Various committees consisting of Participating Providers and Arise Health Plan staff guide, direct, and evaluate quality initiatives. Participating Providers are evaluated using nationally accepted criteria prior to joining the network and are reevaluated every three years thereafter.

Health management studies and projects are completed to increase rates of preventive services and to improve management of acute and chronic diseases. The Quality Improvement Committee is responsible for directing the process of improvement efforts.

Your Rights and Responsibilities

We are committed to maintaining a mutually respectful relationship with you that promotes high quality, cost-effective healthcare.

The rights and responsibilities listed below set the framework for cooperation among you, health care providers and us

1. Your Rights as a Health Plan Member.

You have the right to receive quality health care that's friendly and timely.

You have the right to be treated with respect and recognition of your dignity and right to privacy.

You have the right to receive all medically necessary covered services when your health care providers feel they are needed.

You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

You have the right to refuse treatment.

You have the right to participate with health care providers in making decisions about your health care.

You have the right to all information contained in your medical records.

You have the right to receive information about us, our services, and our network of health care providers as well as your rights and responsibilities.

You have the right to make a list of instructions about your health care treatments (called a living will) and to name the person who can make health care decisions for you.

You have the right to have your medical and financial records kept private.

You have the right to voice complaints or appeals about us or the health care coverage we provide.

You have the right to have a resource at the health plan, clinic, or governing agency that you can contact with any concerns about services and to receive a prompt and fair review of your complaint.

You have the right to make recommendations regarding the member rights and responsibilities policies.

2. Your Responsibilities as a Health Plan Member.

You have the responsibility to select a participating primary care physician and to communicate with him or her in order to develop a patient-physician relationship based on trust, respect, and cooperation.

You have the responsibility to know your health plan benefits and requirements.

You have the responsibility to coordinate all non-life-threatening, in-network care through your participating primary care physician.

You have the responsibility to review your insurance information upon enrollment and to ask questions to verify that you understand the procedures and explanations that are given.

You have the responsibility to supply information (to the extent possible) that our physicians and providers need in order to provide care and that we need in order to provide coverage.

You have the responsibility to understand your health problems and to participate in developing mutually agreed-upon treatment goals to the degree possible.

You have the responsibility to follow the treatment plan and instructions for care that have been agreed on with your physicians.

You have the responsibility to give proof of coverage each time you receive services and to update your clinic with any personal changes.

You have the responsibility to pay copays when you receive services and to promptly pay deductibles, coinsurance, and other charges for services not covered by the policy.

You have the responsibility to keep appointments for care or to give early notice if you need to cancel.

Workers' Compensation

This certificate is not issued in lieu of nor does it affect any requirements for coverage by workers' compensation insurance. Health care services for injuries or illnesses that are job, employment, or work related, or for which benefits are provided or payable under any workers' compensation or occupational disease act or law, are excluded from coverage by us. If a covered person receives benefits under this

certificate for charges that are later determined to be eligible for coverage under any workers' compensation insurance, workers' compensation act, or employer liability law, the covered person shall reimburse us in full to the extent that benefits were paid by us under the policy for such charges. We reserve the right to recover against you even though:

1. The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the illness or injury was sustained in the course of or resulted from employment; or
3. The medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise.

Written Notice

Written notice that we provide to an authorized representative of the policyholder shall be deemed notice to all affected covered persons and their covered dependents. This provision applies regardless of the notice's subject matter.

Claims Processing Procedure

1. Definitions.

Correctly filed claim: a claim that includes: (a) the completed claim forms that we require; (b) the actual itemized bill for each health care service; and (c) all other information that we need to determine our liability to pay benefits under the policy, including but not limited to, medical records and reports.

Incomplete claim: a correctly filed claim that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, or subrogation questionnaire.

Incorrectly filed claim: a claim that is filed but lacks information which enables us to determine what, if any, benefits are payable under the terms and conditions of the policy. Examples include, but are not limited to, claims missing procedure codes, diagnosis or dates of service.

Urgent claim: any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or in the opinion of a physician with actual knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. Procedures.

Benefits payable under the policy will be paid after receipt of a correctly filed claim or prior authorization request. We will notify you of our decision on your claim as follows:

- a. **Concurrent Care.** Prior to the end of any pre-authorized course of treatment, if benefits are reduced or terminated prior to the number of treatments or time period that we authorized. The notice will provide time for you to file a grievance and receive a decision on that grievance prior to the benefit being reduced or terminated. This will not apply if the benefit is reduced or terminated due to a benefit change or termination of the policy.

Request to extend a pre-authorized treatment that involves urgent care must be responded to within 24 hours or as soon as possible if, your condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

- b. Pre-Service Claims.** A pre-service claim is any claim for a benefit under the policy that requires prior authorization before obtaining medical care. For prescription legend drugs, submission of a prescription to a pharmacy or pharmacist will not constitute a claim for benefits under the terms and conditions of the policy. Claims made after 4:00 PM will be logged in and handled on the next business day.

- (1) Urgent Pre-Service Claims.** Within 72 hours of receipt of an urgent pre-service claim or as soon as possible if your condition requires a shorter time frame. You or a health care professional with knowledge of your medical condition may submit the claim to us by telephone, electronic facsimile (i.e. fax) or mail.

If the claim is an incomplete claim or incorrectly filed claim, we will notify you of the specific information needed as soon as possible but no later than 24 hours after we receive your claim. You will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of our receipt of the additional information, we will give our decision on the claim. If you fail to provide the information requested by us, we will provide you with our decision on the claim based on the most current information that we have within 48 hours of the end of the period that you were given to provide the information.

If you fail to follow our procedure for prior authorization requests, we will notify you within 24 hours of our receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining prior approval or precertification.

- (2) Non-Urgent Pre-Service Claims.** Within 15 days of receipt of a non-urgent pre-service claim.

If the claim is an incomplete claim or incorrectly filed claim, we will notify you of a 15 day extension and the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information. Once we have received the additional information, we will make our decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 15-day period. For example, if our notification was sent to you on the fifth day of the first 15-day period, we would have a total of 25 days to make a decision on your claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 75 days from the date we received the non-urgent pre-service claim.

If you fail to follow our procedure for prior authorization requests, we will notify you within five days of our receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining prior authorization.

- (3) Experimental Treatment.** Within 5 business days of receipt of a correctly filed pre-service claim for experimental treatment.

If you file an incomplete claim, an incorrectly filed claim, or if you fail to follow our prior authorization procedure, we will notify you as indicated in paragraph (1) or (2) above, as applicable.

- c. Post-Service Claims.** A post-service claim is any claim for a benefit under the policy that is not a pre-service claim within 30 days of receipt of the claim.

If the claim is an incomplete claim or incorrectly filed claim, we may notify you of a 15 day extension and the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information. Once we have received the additional information, we will make our decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 30-day period. For example, if our notification was sent to you on the fifth day of the first 30-day period, we would have a total of 40 days to make a decision on your claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 90 days from the date we received the post-service claim.

If benefits are payable on charges for services covered under the policy, we'll pay such benefits directly to the hospital, physician or other health care provider providing such services, unless you have already paid the charges and submitted paid receipts therefore to us before we pay benefits. We will send you written notice of the benefits we paid on your behalf. If you have already paid the charges and are seeking reimbursement from us, payment of such benefits will be made directly to you.

If the claim is denied in whole or in part, you will receive a written notice from us explaining why the claim was denied and how you can file a grievance or request an independent external review. Please see Grievance Procedure and Independent External Review procedure below. If our denial or partial denial is based on (1) an internal rule, guideline, protocol or other similar criterion, or (2) the definition of medical necessary or experimental/investigational/unproven, you have the right to request, free of charge, a copy of all information relevant to your claim. Upon request we will also provide you with the meaning of your diagnosis code and/or procedure code.

Grievance/Complaint Procedure

1. Definitions.

Authorized Representative: a person designate to file a grievance on your behalf and/or to act for you. For purposes of your grievance, the authorized representative will be treated as if he/she is the covered person. We will send our written decision responding to the grievance to the authorized representative, not you. Our committee's written decision will contain personal information about you, including your confidential medical information, if any, that applies to the matter which is being grieved.

Complaint: an expression of dissatisfaction that is expressed to us verbally.

Expedited Grievance: means a grievance to which any of the following conditions apply:

- a. The duration of the standard resolution process will result in serious jeopardy to your life or health or your ability to regain maximum function.
- b. A physician with knowledge of your medical condition believes that you are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
- c. A physician with knowledge of your medical condition determines that the grievance shall be treated as an expedited grievance.

An expedited grievance may be submitted verbally or in writing.

Grievance: any dissatisfaction with us or our administration of your health benefit plan that you (or your authorized representative) express to us in writing. For example, you might file a grievance about our provision of services, our determination to reform or rescind a policy, our

determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders, or our claims practices.

You/Your: you, as a covered person, your authorized representative or your physician (if your physician submitted the grievance that pertains to our denial of benefits or coverage for a prescription legend drug or durable medical equipment or a similar medical device).

2. Our Informal Complaint Procedure.

Situations might occasionally arise when you question or are unhappy with a claims decision made by us or some aspect of our policy administration, claims processing, or service that you received from us. For example, you may question why we made a claims decision or denied benefits for a claim submitted. We can resolve most of these questions without you having to file a grievance under this subsection. Therefore, before filing a grievance under this subsection, we urge you to speak with our Customer Service Department to try to resolve any problem, question, or concern that you have. Just call the telephone number on your identification card. A Customer Service representative will record your information and your proposed resolution and consider all information that we have about your policy's terms, conditions, and provisions. If necessary, he/she will then discuss the matter with a supervisor in our Customer Service Department.

We'll respond to your proposed resolution in writing by sending you a letter or an Explanation of Benefits that explains the actions we have taken to resolve the matter. If you are still unhappy after receiving our response, you have the right to file a grievance in writing with our Grievance/Appeal Committee in accordance with the procedure explained below.

3. Grievance Procedure for Grievances That Are Not Expedited Grievances.

- a.** To file a grievance, you should write down the concerns, issues, and comments you have about our services and mail, fax, or deliver the written grievance along with copies of any supporting documents to our Grievance/Appeal Department at the address shown below:

Arise Health Plan
Attention: Grievance Coordinator
P.O. Box 11625
Green Bay, Wisconsin 54307-1625
Fax Number: (920) 490-6955

We cannot accept telephone requests for a grievance. Your grievance must be in writing. Please deliver, fax, or mail your grievance to us at the address shown above.

For example, if we denied benefits for your claim because we determined that a health care service provided to you was not "medically necessary" and/or "experimental" as those terms are defined in the policy, please send us all additional medical information (including copies of your health care provider(s)'s medical records) that shows why the health care service was medically necessary and/or not experimental under the policy.

Any grievance filed by your physician regarding a prescription legend drug or a durable medical equipment or other medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, or durable medical equipment or medical device that's not covered under the policy.

- b.** We will acknowledge our receipt of your grievance by delivering, faxing, or mailing you an acknowledgment letter within five business days of our receipt of the grievance. If you don't receive this acknowledgement, please contact our Customer Service Department using the telephone number on your identification card.

- c. As soon as reasonably possible after we receive your grievance, our Grievance/Appeal Department will review the grievance. Our Grievance/Appeal Department will review the information you provided and consider your proposed resolution in the context of any information we have available about the applicable terms, conditions, and provisions of the policy. If we agree with your proposed resolution, we'll tell you in writing by sending you a letter explaining our subsequent claims processing action or administrative action that resolves the matter to your satisfaction. If our Grievance/Appeal Department upholds the original claims processing or administrative decision that you challenged, the grievance will be automatically forwarded to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained further below. Under no circumstances will the time frame exceed the time periods discussed below.

You have the right to submit written questions to the person or persons responsible for making the determination that is the subject of your grievance. The responses to your questions will be considered in the Grievance Committee's review of your grievance.

For decisions regarding medical judgment, we will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. You have the right to request the identity of the health care professional whose advice we obtained in connection with the adverse benefit determination, regardless of whether we relied upon such advice in making our decision.

In general, the Grievance Committee will reach and issue its decision to you within 30 days. If, however, the Committee determines that it needs additional time to make its decision, the committee will mail you a written notice before the 30-day period has expired. This notice will explain that the Committee needs an extension of time to complete its review and make its decision and will indicate how much additional time we need, when the committee's decision is expected to be made, and the reason additional time is needed. The Committee then has an additional 30 days after the first 30-day period has expired (or within 60 days from the date we first received the grievance) to provide you with its written decision.

- d. You have a right to appear in person or to participate by teleconference before the Grievance/Appeal Committee which meets at our offices in DePere, Wisconsin, and to present written or oral information to the committee and to submit written questions to the Committee. In the Committee's written decision to the grievance the Committee will respond to all of the written questions submitted to the Committee prior to or at that meeting. The Committee will notify you in writing of the time and place of the meeting at least seven calendar days before the meeting. Please remember that this meeting is not a trial where there are rules of evidence that are followed. Also, cross-examination of the Committee's members, its advisors, or Arise Health Plan employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the Committee. The person's presentation to the Committee may be tape-recorded by the Committee. If you attend the meeting to present the reason(s) for the grievance, we expect and require each person who attends the meeting to follow and abide by the internal practices, rules and requirements established by the Committee to handle grievances effectively and efficiently in accordance with the applicable laws and regulations.
- e. Within 30 (or 60) days after our receipt of the grievance, the Grievance/Appeal Committee will mail you a detailed decision letter containing all information required by law. The letter will be sent to the person who filed the grievance by regular mail unless that person's grievance asked the Committee to transmit its written decision by fax.
- f. We will retain our records of the grievance for at least six years after we send you the Committee's letter providing written notification of its decision. You have the right to request a copy of documents, free of charge, relevant to your grievance by sending a written request to the address listed above.

- g.** If we continue to deny the payment, coverage, or service requested, or if you do not receive a timely decision, you may be entitled to request an independent external review.

4. Grievance Procedure for Grievances That Are Expedited Grievances.

- a.** To file an expedited grievance, you or your health care provider must submit the concerns, issues, and comments underlying your grievance to us via telephone, mail, email, or fax using the contact information below. If you contact us initially by phone, you will need to submit copies of any supporting documents via email, fax or mail:

Arise Health Plan
Attention: Grievance Coordinator
P.O. Box 11625
Green Bay, Wisconsin 54307-1625
Phone: (920) 490-6900 or toll-free 1-888-711-1444
Fax Number: (920) 490-6955

For example, if we denied benefits for your claim because we determined that a health care service provided to you was not “medically necessary” and/or “experimental” as those terms are defined in the policy, please send us all additional medical information, including sending us copies of your health care provider(s)’s medical records, that you believe shows that the health care service was medically necessary and/or not experimental under the policy. Any grievance filed by your physician regarding a prescription legend drug or durable medical equipment or a medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, or durable medical equipment or medical device that’s not covered under the policy.

- b.** As soon as reasonably possible following our receipt of the expedited grievance, our Grievance/Appeal Department will review the expedited grievance. Our Grievance/Appeal Department will take the information along with your proposed resolution and review the matter, including considering all information that we have available and the policy’s applicable terms, conditions, and provisions. If we agree with the proposed resolution of this matter, we’ll contact you by phone or fax to explain our decision and then follow up with either a letter or an Explanation of Benefits form explaining how we resolved your grievance. If our Grievance/Appeal Department upholds our original claims processing decision or administrative decision that you disputed, the grievance will be automatically forwarded to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained below. For decisions regarding medical judgment, we will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. You have the right to request the identity of the health care professional whose advice we obtained in connection with the adverse benefit determination, regardless of whether we relied upon such advice in making our decision.
- c.** As expeditiously as your health condition requires, but not later than 72 hours after our receipt of the expedited grievance, the Grievance/Appeal Department will contact you by phone or fax to explain the Grievance/Appeal Committee’s rationale and decision. The Committee will then mail a detailed decision letter containing all information required by law. The letter will be mailed to the person who filed the expedited grievance using the United States Postal Service.
- d.** We will retain our records of the grievance for at least six years after we send you the committee’s letter providing written notification of its decision.
- e.** You have the right to request a copy of documents, free of charge, relevant to your grievance by sending a written request to the address listed above.

- f. If we continue to deny the payment, coverage, or service requested, or if you do not receive a timely decision, you may be entitled to request an independent external review.

Independent External Review

1. Definitions.

The following definitions apply to this subsection only:

Experimental Treatment Determination: a determination by Arise Health Plan to which all of the following apply:

- a. we have reviewed the proposed treatment;
- b. based on the information provided, we have determined the treatment is experimental/ investigational/ unproven;
- c. based on the information provided, we denied the treatment or payment for the treatment.

Adverse Determination: a determination by Arise Health Plan to which all of the following apply:

- a. we have reviewed admission to a health care facility, the availability of care, the continued stay or other treatment;
- b. based on the information provided, the treatment does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
- c. based on the information provided, we reduced, denied or terminated the treatment or payment of the treatment.

An adverse determination also includes the denial of a prior authorization request for health care services from a non-participating provider. The right to an independent external review applies only when you feel the non-participating provider's clinical expertise is medically necessary and the expertise is not available from a participating provider.

Rescission of Coverage Determination: a determination by Arise Health Plan to withdraw coverage under the policy back to your initial date of coverage, modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability.

2. Independent External Review Process.

You may be entitled to an independent external review by an Independent Review Organization (IRO) if you have received an experimental treatment determination, adverse determination or a rescission of coverage determination.

In general, you must complete all grievance/appeal options before requesting an independent external review. This includes waiting for our determination on your grievance/appeal. However, if we agree with you that the matter should proceed directly to independent review, or if you need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize your life or health, you may ask to bypass our internal grievance process. In these situations, your request will be processed on an expedited basis.

If you or your authorized representative wish to file a request for an independent external review, your request must be submitted in writing to the address listed below and received within four months of the decision date of your grievance.

Arise Health Plan
Attention: Grievance Coordinator
P.O. Box 11625
Green Bay, Wisconsin 54307-1625

Your request for an independent external review must include:

- a. your name, address and telephone number.
- b. an explanation of why you believe that the treatment should be covered.
- c. any additional information or documentation that supports your position.
- d. if someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative.
- e. any other information requested by us.

Within five days of our receipt of your request, an accredited IRO will be assigned to your case through an unbiased random selection process. The assigned IRO will send you a notice of acceptance within one business day of receipt, advising you of your right to submit additional information within ten business days of your receipt of the notice from the IRO. The assigned IRO will also deliver a notice of the final external review decision in writing to you and Arise Health Plan within 45 calendar days of their receipt of the request. Some of the information you provide to the IRO may be shared with appropriate regulatory authorities.

Unless your case involves the rescission of the policy, the IRO's decision is binding for both you and Arise Health Plan. You are not responsible for costs associated with the independent external review.

*You may resolve your problem by taking the steps outlined above. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:*

*Office of the Commissioner of Insurance
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873
ocicomplaints@wisconsin.gov*

or you can call 1-800-236-8517 outside of Madison or (608) 266-0103 in Madison, and request a complaint form.