Certificate of Coverage - PPO
Wisconsin Physicians Service Insurance Corporation
1717 West Broadway P.O. Box 8190 Madison, Wisconsin 53708-8190

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NON-PREFERRED PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-preferred provider for a covered health care service, benefit payments to such non-preferred providers are not based upon the amount billed. The basis of your benefit payment will be determined according to your Schedule of Benefits and the maximum allowable fee, as determined by us. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-preferred providers may bill you for any amount up to the billed charge after we have paid our portion of the bill. Preferred providers have agreed to accept discounted payment for covered health care services with no additional billing to you other than copayment, coinsurance and deductible amounts. You may obtain further information about the preferred status of health care providers and information on out-of-pocket expenses by calling the Customer Service toll-free telephone number on your identification card or visiting our website at wpshealth.com.

This Certificate of Coverage (the “Certificate”) 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, Wisconsin Physicians Service Insurance Corporation (hereinafter “WPS”, “we”, “our”, or “us”) will not pay for most health care services under the Policy until you have paid certain out-of-pocket amounts, called annual deductibles. Please see the Schedule of Benefits to determine your annual deductible amounts. Other cost-sharing aspects of the Policy, such as coinsurance and copayments, are discussed in Section 4. (Payment of Benefits). Please review that section carefully so that you understand what your share of each health care expense will be under the Policy.

You are responsible for choosing your preferred provider from our most recent Preferred Provider Directory. The preferred providers and all other health care providers are independent contractors and are not employed by WPS. WPS merely provides benefits for covered expenses in accordance with the group policy. WPS does not provide health care services. WPS does not warrant or guarantee the quality of the health care services provided by any preferred provider or any other health care provider. WPS is not liable or responsible in any way for the provision of such health care services by any preferred provider or any other health care provider. Please see Section 10. A. (General Provisions / Your Relationship with Your Health Care Practitioner, Hospital or Other Health Care Provider).

The amount we pay for a covered health care service will always be limited to the maximum allowable fee, as defined in Section 14. (Definitions). This amount may be less than the amount billed and in certain cases, you will be responsible for paying the difference. If you would like more information, please contact our Customer Service Department by calling the telephone number shown on your WPS 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, WPS is acting only as a health insurer with respect to the Policy. We are 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 law.
The Policy is issued by WPS and delivered to the policyholder in Wisconsin. All terms, conditions, and provisions of the Policy, including, but not limited to, all exclusions and coverage limitations contained in the Policy, are governed by the laws of Wisconsin. All benefits are provided in accordance with the terms, conditions, and provisions of the Policy, any endorsements attached to this Certificate, your completed application for this insurance, and applicable laws and regulations.

Wisconsin Physicians Service Insurance Corporation

Michael F. Hamerlik
President and Chief Executive Officer
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1. GENERAL INFORMATION

A. General Description of Coverage

WPS has issued a Group Master Policy to the policyholder. The Group Master Policy forms a contract between us and your employer under which we provide health insurance coverage for certain employees and their dependents. This Certificate describes the health insurance benefits you are entitled to receive as a covered person. We provide the benefits described in this Certificate under the terms, conditions, and provisions of the Group Master Policy.

This Certificate describes the two benefit levels. One benefit level applies when you receive covered health care services from a preferred provider. The other benefit level applies when you receive covered health care services from a non-preferred provider.

This Certificate replaces and supersedes any certificates we issued to the policyholder before the effective date of the Group Master Policy and any written or oral representations that we or our representatives made.

B. Entire Contract

The entire contract between you and us is made up of the Group Master Policy, the policyholder's group application, any supplemental policyholder applications, this Certificate, the Schedule of Benefits, any endorsements, your application, and any supplemental applications. These documents are collectively referred to as the “Policy.”

C. How to Use This Certificate

You should read this Certificate, including its Schedule of Benefits and all endorsements, carefully and completely. 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 full understanding of your coverage under the Policy.

Each italicized term used in this Certificate has a special meaning, which is explained in Section 14. (Definitions) or in the definitions section of the relevant subsection. Whenever you come across an italicized word, please review its definition carefully so you understand what it means.

Throughout this Certificate, the terms “you” and “your” refer to any covered person. The terms “we”, “us”, and “our” refer to WPS.

D. How to Get More Information

When you have questions about your coverage or claims, contact our Customer Service Department by calling the telephone number shown on your identification card. You can also find lots of additional information and answers to common questions on our website, wpshealth.com. We also recommend that you register for an WPS online member account, where you can access your Explanation of Benefits (EOBs) and Policy materials, check your claims processing status, find a preferred provider, verify Policy benefits, and check your deductible.

E. Your Choice of Health Care Providers Affects Your Benefits

Preferred providers are health care providers who are part of our network as shown on your WPS identification card. See Section 14. (Definitions) for more information.

If you use a preferred 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 allow and the amount the preferred provider bills, you are not responsible for that amount.

Non-preferred providers are health care providers who have not agreed to participate in the health care network shown on your WPS identification card.
If you use a non-preferred provider, covered charges will be payable under this policy up to the maximum out-of-network allowable fee as defined in Section 14. (Definitions). If there is a difference between the amount that we pay and the amount that the non-preferred provider bills, you are responsible for that amount.

F. Covered Expenses

The Policy only provides benefits for certain health care services. Just because a health care provider 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. 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 have full discretionary authority to pay benefits for health care services: (1) at the preferred provider level of benefits for a health care service provided by a non-preferred provider; or (2) that are not covered under the Policy, to the limited extent provided in Section 5. C. (Covered Expenses / Alternative Care). The fact that we provide such coverage in one case will not require us to do so in any other case, regardless of any similarities between the two.

We have full discretionary authority to arrange for other persons or entities to provide administrative services related to the Policy, including claims processing and utilization management without notice to you. We also have full discretionary authority to authorize other persons or entities to exercise discretionary authority with regard to the Policy without notice to you. By accepting this Certificate, you agree to cooperate fully with those persons or entities in the performance of their responsibilities.

2. ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE

A. Employee Eligibility

An individual who meets the definition of eligible employee is eligible for coverage under the Policy as stated in this Section 2., unless the policyholder’s application for coverage indicates a waiting period.

An individual who ceases to qualify as an eligible employee may continue coverage under the Policy in certain circumstances. See Section 8. D. (When Coverage Ends / Extension of Benefits) for more details.

B. Dependent Eligibility

Any family members that meet the definition of eligible dependent will become eligible for coverage under the Policy when the eligible employee becomes eligible for coverage. Subscribers may also enroll new eligible dependents who join their family because of birth, legal adoption, placement for adoption, marriage, legal guardianship, or court or administrative order. See Subsection F. (Special Enrollment Periods) below for more information about these special enrollment opportunities.

C. Initial Enrollment Period

When the group purchases coverage under the Policy, the initial enrollment period is the first period of time when eligible employees can enroll themselves and their eligible dependents. Coverage begins on the date identified in the Policy as long as we receive the completed application and any required premium within 31 days after the employee and any dependents become eligible to enroll. If an eligible employee and his/her eligible dependents do not enroll for coverage within this period and he/she is not otherwise eligible for a special enrollment period, as outlined in Subsection E. (Special Enrollment Periods) below, he/she must wait to enroll for coverage during the next annual enrollment period as stated in Subsection D. (Annual Enrollment Period) below.

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.
D. Annual Enrollment Period

Each year there will be an enrollment period during which any eligible employee and/or eligible dependents can enroll under the Policy. The annual enrollment period also provides an opportunity for a subscriber to change to a different health insurance plan, if available. Any coverage selected will be effective on the first day of the month following the annual enrollment period.

If an eligible employee or eligible 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 a special enrollment period.

The annual enrollment period will be the month prior to the policyholder’s anniversary date. The application for coverage must be received prior to policyholder’s anniversary date.

E. Special Enrollment Periods

Certain life events or other circumstances may trigger a special enrollment period during which an eligible employee or eligible dependent will be able to enroll in the Policy outside the annual enrollment period. These circumstances are explained in Paragraphs 1 – 7 below.

Except as noted below, we generally must receive an application from the eligible employee listing all individuals he/she wants to enroll within 31 days after the eligible employee or eligible dependent experiences the special late enrollment circumstance (e.g., birth, marriage, loss of coverage).

If an eligible employee has completed any waiting period required by the policyholder, he/she may enroll himself/herself and his/her eligible dependents if the eligible employee acquires an eligible dependent through marriage, birth, or adoption or placement for adoption.

If we timely receive an application, coverage for the eligible 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 eligible employee experiences the special late enrollment circumstance due to birth, adoption or placement for adoption of a child, or by court order. If we do not receive the application within this time period, you may have to wait until the next annual enrollment period to add or change your coverage.

1. Eligibility for Premium Assistance Subsidy under Medicaid

If an eligible employee or eligible dependent previously declined coverage under the Policy, but later becomes eligible for a premium assistance subsidy under Medicaid, including BadgerCare Plus or the Children’s Health Insurance Program (CHIP), the eligible employee or eligible dependent may enroll in the Policy by submitting an application within 60 days after they are determined to be eligible for the subsidy.

2. Loss of Other Health Care Coverage

If an eligible employee or eligible dependent initially declined enrollment in the Policy because of other health care coverage, the eligible employee or eligible dependent may enroll in the Policy if they lose eligibility for that other coverage. A special enrollment period is not available to an eligible employee or eligible dependent if the other health care coverage was terminated for cause or because premiums were not paid on a timely basis.

In order to qualify for a special enrollment period due to loss of other health care coverage, all of the following must be true:

a. The eligible employee submitted an application within 31 days of his/her initial date of eligibility and waived coverage for himself/herself and/or his/her eligible dependents because the eligible employee and/or eligible dependents had other health care coverage;

b. The eligible employee and/or his/her eligible dependents had other health care coverage when the eligible employee initially waived coverage under the Policy; and

c. The eligible employee and/or eligible dependents lost the other health care coverage that they had when they waived the benefits of the Policy because of any of the following:
1) Loss of eligibility;
2) Contributions made on your behalf towards your other health care coverage ended;
3) COBRA continuation coverage ended;
4) The eligible employee and/or eligible dependent no longer lives or works in the plan’s geographical service area and no other benefit option is available;
5) The plan no longer offers benefits to a class of individuals that includes the eligible employee and/or eligible dependent;
6) The eligible employee and/or eligible dependent incurs a claim that would exceed a lifetime limit on all benefits; or
7) The eligible employee and/or eligible dependent loses eligibility for Medicaid, including BadgerCare Plus or the Children’s Health Insurance Program (CHIP).

If health care coverage is lost for one of the reasons outlined in Paragraph 2. c. (1 – 6) above, coverage for the eligible employee and/or his/her eligible dependents under the Policy will begin on the first day of the calendar month following the date the eligible employee’s other health coverage ended if we receive an application within 31 days after the loss of other health care coverage. If health care coverage is lost for the reason outlined in Paragraph 2. c. 7. (loss of eligibility for Medicaid), coverage for the eligible employee and/or his/her eligible dependents under the Policy will begin on the first day of the calendar month following the date the eligible employee’s or eligible dependent’s other health coverage ended if we receive an application within 60 days after the loss of other health care coverage. Otherwise, the eligible employee and/or eligible dependents may not be added until the next annual enrollment period.

3. Marriage

If a subscriber acquires one or more eligible dependents through marriage, he/she may enroll any eligible dependents. If we receive an application within 31 days after the date of marriage, the eligible dependents’ coverage will be effective on the date of marriage. Otherwise, the spouse and other eligible dependents may not be added until the next annual enrollment period.

4. Birth of a Child

Coverage is provided for a newborn biological child who meets the definition of eligible dependent 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. If coverage is needed to continue after the 60 days, you must add the child. To add a newborn biological child, you must submit an application and pay any required premium within 60 days after the date of birth. If you fail to notify us and do not make any required payment beyond the 60-day period, coverage will end, unless you make all past due payments with 5.5% interest, within one year of the child’s birth. In this case, benefits are retroactive to the date of birth. If we do not receive the application within one year after the child’s birth, the newborn may not be added until the next annual enrollment period.

5. Adoption of a Child or a Child Placed for Adoption

If a subscriber wishes to obtain coverage for a child because of the child’s adoption or placement for adoption the policyholder must receive an application listing the child within 60 days after the date of the adoption or placement for adoption. The effective date for coverage will be one of the following: (a) the date a court makes a final order granting adoption of the child by the subscriber; (b) the date that the child is placed for adoption with the subscriber; or (c) a later date elected by the subscriber. If the policyholder receives the application after the 60-day enrollment period ends, the child may not be added until the next annual enrollment period.

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

6. Child Support Order

We will provide coverage in accordance with a Qualified Medical Child Support Order (QMCSO), National Medical Support Notice (NMSN), or other qualified medical child support order pursuant to the applicable requirements under
§ 609 of the Employee Retirement Income Security Act (ERISA) and § 1908A of the Social Security Act and any other applicable laws. It is the policyholder’s responsibility to determine whether a medical child support order is qualified.

Upon receipt of a medical child support order issued by an appropriate court or governmental agency, the policyholder will follow its established procedures for determining whether the medical child support order is qualified. The policyholder will provide us with notice of the medical child support order and a copy of the order along with an application for coverage within the greater of 31 days after issuance of the order or the time in which the policyholder provides notice of its determination to the persons specified in the order.

Where a medical child support order requires coverage to be provided under the Policy and an eligible employee’s child is not already a covered dependent, then such child will be provided a special enrollment period. If the eligible employee whose child is the subject of the medical child support order is not enrolled at the time enrollment for the child is requested, then the eligible employee must also enroll for coverage under the Policy during the special enrollment period. The effective date of coverage will either be the date the medical child support order is issued or pursuant to another coverage date set forth in the medical child support order.

Where a medical child support order requires coverage to be provided for under the Policy for an eligible employee’s child who is already a covered dependent, such child will continue to be provided coverage under the Policy pursuant to the terms of the medical child support order.

7. Adding a Domestic Partner

This Paragraph 7. only applies if shown in the policyholder’s current application for coverage as being applicable. If a subscriber wants to add a domestic partner and his/her domestic partner’s children the subscriber must apply for coverage within 31 days of the date the subscriber registers such partner as a domestic partner with us. To register a domestic partner, we must receive a completed “Declaration of Domestic Partnership Affidavit” on a form approved by us.

The coverage effective date for the domestic partner and the domestic partner’s children, if applicable, will be the first of the month following our receipt of the completed application and affidavit. If we receive an application after that 31-day period ends, the domestic partner and the domestic partner’s children, if any, may not be added until the next annual open enrollment period.

3. OBTAINING SERVICES

A. Prior Authorization

1. What is Prior Authorization? Prior authorization is the process we use to determine if a prescribed health care service, including certain prescription legend drugs is covered under the Policy before you receive it. This process is intended to protect you from unnecessary, ineffective, and unsafe services and to prevent you from becoming responsible for a large bill for health care services or prescription legend drugs that are not covered by the Policy.

2. When Do I Have to Obtain Prior Authorization? You are required to obtain prior authorization before you visit certain health care providers or receive certain health care services, such as planned inpatient admissions, pain management, spinal surgery, new technologies (which may be considered experimental/investigational/unproven), non-emergency ambulance services, high-cost durable medical equipment, genetic testing, prescription legend drugs, or procedures that could potentially be considered cosmetic treatment. A current list of health care providers and health care services for which prior authorization is required is located on our website at wpshealth.com. Please refer to this website often, as we have full discretionary authority to change it from time to time without notice to you.

3. How do I Request Prior Authorization?

a. Health Care Services Other Than Prescription Legend Drugs: Ask your health care practitioner to contact our Customer Service Department by calling the telephone number shown on your identification card or to download, complete, and submit the printable Prior Authorization Form on our website. You should then call Customer Service to verify that we have received the prior authorization request. Please note that for genetic
services, we will not accept prior authorization requests from the laboratory that will perform the genetic services unless there is supporting documentation from the ordering health care provider.

b. Prescription Legend Drugs: Prescription legend drugs that require prior authorization are noted on our website at wpshealth.com. Your health care practitioner should contact us, or our delegate, as indicated, to initiate the process. To find out about the prior authorization process for prescription legend drugs, see Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies).

4. What Happens After My Provider Submits the Prior Authorization Request? After we, or our delegate, receive your health care provider’s request, we, or our delegate, will review all of the documentation provided and send a written response to you and/or the health care provider who submitted the request within the timeframe required by law. See Section 11. (Claim Filing and Processing Procedures) and 12. (Internal Grievance and Appeals Procedures) for additional details.

5. What Are My Responsibilities During the Prior Authorization Process? Although your health care provider should initiate the prior authorization process, it is your responsibility to ensure that we have approved the prior authorization request before you obtain the applicable health care services.

6. My Prior Authorization Request Was Approved – Now What? If we, or our delegate, 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.

7. My Prior Authorization Request Was Denied – Now What? If we disapprove your request for a health care service, you can request that we review and reconsider the denial of benefits by following the procedures outlined in Sections 11. (Claim Filing and Processing Procedures) and 12. (Internal Grievance and Appeals Procedures).

8. What Happens If I Do Not Obtain a Prior Authorization? Failure to comply with our prior authorization requirements will initially result in no benefits being paid under the Policy. If, however, benefits are 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 procedures outlined in Sections 11. (Claim Filing and Processing Procedures) and 12. (Internal Grievance and Appeals Procedures). If we determine that the health care service would have been covered under the Policy if you had followed the prior authorization process, we will reprocess the affected claim(s) in accordance with your standard benefits.

9. What Health Care Services Do Not Require a Prior Authorization? You do not need a prior authorization from us or any other person (including your primary care provider) to obtain emergency medical care or urgent care at an emergency or urgent care facility.

B. Coding Errors

In some cases, we may deny a claim if we determine that the health care provider or its agent did not use the appropriate billing code to identify the health care service provided to you. We follow the coding guidelines of the Center for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS) and the International Class of Diseases and Related Health Problems 10th Edition (ICD-10).

C. Our Utilization Management Program

Utilization management (UM) is the evaluation of whether a health care service is medically necessary. 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 is medically necessary. If you choose to receive a health care service that we determine is not medically necessary, you will be responsible for paying all charges and no benefits will be paid under the Policy.

D. Continuity of Care

To the limited extent required by Wis. Stat. § 609.24 and Wis. Admin. Code § Ins 9.35, we will provide benefits at the preferred provider level for health care services received from any provider if we represented during the most recent open enrollment period that the provider was or would be a preferred provider. We will continue to cover services for a covered person who is in the second or third trimester of pregnancy until the completion of postpartum care for the covered person and the infant. This provision does not apply when: (1) the provider no longer practices within the area in which we are authorized to do business; or (2) the provider’s participation with us is terminated because of his/her misconduct.

This Subsection D. does not in any way expand or provide greater coverage of any health care provider’s health care services beyond what we determine to be the minimum “continuity of care” requirements set forth in Wis. Stat. § 609.24 and Wis. Admin. Code § Ins 9.35. If you have any questions, please do not hesitate to contact our Customer Service Department at the telephone number shown on your WPS identification card.

4. PAYMENT OF BENEFITS

Any payment of benefits under the Policy is subject to: (1) the applicable deductible; (2) applicable coinsurance; (3) the applicable copayment; (4) your out-of-pocket limit; (5) exclusions; (6) our prior authorization requirements; (7) our maximum allowable fee; (8) all other limitations shown in the Schedule of Benefits; and (9) all other terms, conditions and provisions of the Policy.

A. Deductible

Each year, you are required to pay a deductible before most benefits are payable under the Policy. Your deductible is shown in the Schedule of Benefits. No benefits are payable under the Policy for charges used to satisfy your deductible.

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

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

B. Coinsurance

After you satisfy your deductible, you will only be responsible for the copayment and coinsurance amounts shown in the Schedule of Benefits. Any applicable coinsurance will apply until you have reached your out-of-pocket limit.

C. Copayments

Your copayments (if applicable) are set forth in your Schedule of Benefits. Copayment amounts may vary by the type of service. You may also have a copayment when you get a prescription filled. See Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies) for information about prescription copayments.

If you receive health care services other than emergency room care at a hospital-based outpatient clinic or location, your bill may show two separate charges – one for the health care practitioner and one for the facility. The copayment only applies to the charge billed by the health care practitioner. Facility charges are subject to the applicable deductible and coinsurance amounts of the Policy. See Section 5. T. (Covered Expenses / Emergency Medical Care.)
D. Out-of-Pocket Limits

Your out-of-pocket limits are set forth in your Schedule of Benefits. 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 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-preferred provider and paid at the preferred provider level of benefits shall be applied to the preferred provider out-of-pocket limit shown in the Schedule of Benefits.

E. Maximum Allowable Fee

We’ll pay charges for the covered expenses described in Section 5. (Covered Expenses) up to the maximum allowable fee. If you see a non-preferred 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; (2) the procedure code, if applicable; (3) the name of the health care provider providing the service; and (4) the facility where the service will be provided.

5. COVERED EXPENSES

Health care services described in this Section 5. are covered expenses as long as they are medically necessary, ordered and provided by a health care provider licensed to provide them and not subject to an exclusion or limitation outlined in this section and Section 6. (General Exclusions). If a health care service is not listed in this Section 5., it is not covered under the Policy and no benefits are payable for it.

Please note that any of the health care services listed below may require our prior authorization. Please see Section 3. A. (Obtaining Services / Prior Authorization) for detailed information about our prior authorizations. Additionally, all benefits are subject to the deductible, coinsurance and, copayment amounts, out-of-pocket limits and all other provisions stated in the Schedule of Benefits. See Section 4. (Payment of Benefits) for an explanation of these cost-sharing structures.

A. Alcoholism Treatment

See Section 5. G. (Behavioral Health Services) for benefits for alcoholism and other substance use disorders.

B. Allergy Testing and Treatment

Therapy and testing for treatment of allergies.

C. Alternative Care

If your attending health care practitioner advises you to consider alternative care for an illness or injury that includes health care services not covered under the Policy, your attending health care practitioner should contact us so we can discuss it with him/her. We have full discretionary authority to consider paying for such non-covered health care services and we may consider an alternative care plan if 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 health care services provided under the alternative care plan will be as cost effective as the 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, will be determined by us.

Any alternative care decision must be approved by you, the attending health care practitioner, and us before such alternative care begins.

D. Ambulance Services

1. Ambulance services used to transport you when you are sick or injured:
   a. From your home or the scene of an accident or medical emergency to a hospital
   b. Between hospitals
   c. Between a hospital and a skilled nursing facility
   d. From a hospital or a skilled nursing facility to your home for hospice care
   e. From your home to a facility for hospice care covered under Section 5. Z. (Covered Expenses / Hospice Care).

2. 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 D. If, however, the ambulance service bills emergency medical care separate from the transport services, benefits will be payable as stated elsewhere in the applicable provisions of the Policy.

3. Emergency ambulance transports must be made to the closest local facility or preferred provider 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.

4. Benefits are not payable for ambulance services:
   a. When you can use another type of transportation without endangering your health.
   b. When ambulance services are used solely for the personal convenience or preference of you, a family member, health care practitioner, or other health care provider.
   c. When ambulance services are provided by anyone other than a licensed ambulance service.
   d. When ambulance services are called, but you are not transported (please note that any emergency medical care provided to you will be payable under Section 5. T. (Emergency Medical Care)).

E. Anesthesia Services

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

F. Autism Services

Benefits are payable for charges for covered expenses as described below in Paragraph 1. (Covered Autism Services) for covered persons who have a primary verified diagnosis of autism spectrum disorder, which includes autism disorder, Asperger’s syndrome, and pervasive development disorder not otherwise specified. A verified autism spectrum disorder diagnosis determination must be made by a health care practitioner skilled in testing and in the use of empirically-validated tools specific for autism spectrum disorders. We may require confirmation of the primary diagnosis through completion of empirically-validated tools or tests from each of the following categories: intelligence, parent report, language skills,
adaptive behavior and direct observation of the covered person. Please see Wisconsin Administrative Code Ins. 3.36 for applicable definitions.

This Section 5. F. is not subject to the exclusions in Section 6. (General Exclusions). The only exclusions that apply to this Section 5. F. are outlined below in Paragraph 2. (Autism Services Exclusions), except for durable medical equipment and prescription legend drugs. Please see Sections 5. S. (Durable Medical Equipment) and 5. LL. (Prescription Legend Drugs and Supplies).

1. Covered Autism Services:
   a. Diagnostic testing. The testing tools used must be appropriate to the presenting characteristics and age of the covered person and empirically valid for diagnosing autism spectrum disorders consistent with the criteria provided in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. We reserve the right to require a second opinion with a provider mutually agreeable to the covered person and us.
   b. Intensive-level services. We will provide up to four years of intensive-level services that commence after you are two years of age and before you are nine years of age. The majority of the services must be provided to you when your parent or legal guardian is present and engaged. While receiving intensive-level services, you must be directly observed by the qualified provider at least once every two months. In addition, the intensive-level services must be all of the following:
      1) Evidence-based;
      2) Provided by a qualified provider, professional, therapist, or paraprofessional, as those terms are defined by state law;
      3) Based on a treatment plan developed by a qualified provider or professional as defined by state law that includes an average of 20 or more hours per week over a six-month period of time with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that you be present and engaged in the intervention;
      4) Provided in an environment most conducive to achieving the goals of your treatment plan;
      5) Assessed and documented throughout the course of treatment. We may request and review your treatment plan and the summary of progress on a periodic basis; and
      6) Designed to include training and consultation, participation in team meetings and active involvement of the covered person’s family and treatment team for implementation of the therapeutic goals developed by the team.
   c. Concomitant services by a qualified therapist. We will cover services by a qualified therapist when all the following are true:
      1) The services are provided concomitant with intensive-level evidence-based behavioral therapy;
      2) You have a primary diagnosis of an autism spectrum disorder;
      3) You are actively receiving behavioral services from a qualified intensive-level provider or qualified intensive-level professional; and
      4) The qualified therapist develops and implements a treatment plan consistent with their license and this Section 5. F.
   d. Non-intensive-level services. You are eligible for non-intensive-level services, including direct or consultative services, that are evidence-based and are provided by a qualified provider, supervising provider, professional, therapist or paraprofessional under one of the following scenarios: (i) after the completion of intensive-level services, as long as the non-intensive-level services are designed to sustain and maximize gains made during the intensive-level treatment; or (ii) if you have not and will not receive intensive-level services but non-
intensive-level services will improve your condition. Non-intensive-level services must be all of the following:

1) Based upon a treatment plan and include specific 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;

2) Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law.

3) Provided in an environment most conducive to achieving the goals of your treatment plan;

4) Designed to provide training and consultation, participation in team meetings and active involvement of the covered person’s family in order to implement therapeutic goals developed by the team;

5) Designed to provide supervision for qualified professionals and paraprofessionals in the treatment team; and

6) Assessed and documented throughout the course of treatment. We may request and review your treatment plan and the summary of progress on a periodic basis.

2. Autism Services Exclusions:

This Section 5. F. is only 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 care or respite care

i. Special diets or supplements

j. Provider travel expenses

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

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
G. Behavioral Health Services

1. Covered Behavioral Health Services:
   a. Inpatient hospital services
   b. Outpatient services
   c. Transitional treatment

2. Review Criteria for Transitional Treatment:
   a. 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:
      1) The transitional treatment is certified by the Department of Health Services;
      2) The transitional treatment meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;
      3) The specific diagnosis is consistent with the symptoms;
      4) The transitional treatment is standard medical practice and appropriate for the specific diagnosis;
      5) The transitional treatment plan is focused for the specific diagnosis; and
      6) 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.
   b. We will need the following information from the health care provider to help us determine if the transitional treatment is medically necessary:
      1) A summary of the development of your illness and previous treatment.
      2) A well-defined treatment plan listing treatment objectives, goals and duration of the care provided under the transitional treatment program.
      3) 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.

3. Behavioral Health Services Exclusions:
   The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Health care services to treat academic problems not due to a clinically diagnosed nervous or mental disorder, or health care services a child’s school is legally required to provide, whether or not the school actually provides them and whether or not a covered person chooses to use those services.
   b. Behavioral health care services or treatment for, or in connection with, developmental delays. Please see Section 5. TT. (Therapy Services), which provides benefits for other health care services provided for or in connection with developmental delays.
   c. Treatment of a behavioral or psychological problem that is not due to a clinically diagnosed nervous or mental disorder. Examples include occupational problems such as job dissatisfaction, antisocial behavior, parent-child problems such as impaired communication or inadequate discipline, marital problems, and other interpersonal problems.
   d. Bereavement counseling.
   e. Marriage counseling.
f. Charges for health care services provided to or received by a covered person as a collateral of a patient when those health care services do not enhance the treatment of another covered person under the Policy.

H. Blood and Blood Plasma

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

I. Cardiac Rehabilitation Services

1. Covered Cardiac Rehabilitation Services:
   a. Phase I cardiac rehabilitation sessions while you are confined as an inpatient in a hospital.
   b. Up to 36 supervised and monitored Phase II cardiac rehabilitation sessions per covered illness while you are an outpatient receiving services in a facility with a facility-approved cardiac rehabilitation program.

2. Cardiac Rehabilitation Exclusions:

   The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Cardiac rehabilitation beyond Phase II.
   b. Behavioral or vocational counseling.

J. Chiropractic Services

For therapy benefits, please see Section 5. UU. (Therapy Services).

1. Covered Chiropractic Services:

   Medically necessary services and diagnostic tests provided by a chiropractor.

2. Chiropractic Services Exclusion:

   The Policy provides no benefits for chiropractic services, which are considered maintenance care or supportive care. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

K. Clinical Trials

1. Benefits.

   Routine patient care costs that you incur while participating in a qualifying clinical trial for the treatment of cancer, cardiovascular disease (cardiac/stroke); surgical musculoskeletal disorders of the spine, hip and knees or other diseases or disorders for which we determine a clinical trial meets the qualifying clinical trial criteria. Benefits are available only when you are eligible to participate in an approved clinical trial according to the trial protocol.

L. Cognitive Rehabilitation Therapy

Outpatient cognitive rehabilitation therapy following a brain injury or cerebral vascular accident limited to 20 visits per calendar year. No other benefits are payable for cognitive rehabilitation therapy services.

M. Colorectal Cancer Screening and Diagnosis

Routine colorectal cancer screenings are covered as preventive screenings under Section 5. MM. (Preventive Care Services). Diagnostic colorectal cancer tests are covered under Section 5. Q. (Diagnostic Services) and Section 5. TT. (Surgical Services).
N. Contraceptives for Birth Control

FDA-approved contraceptive methods prescribed by a health care practitioner, including related health care services. Examples of devices, medications, and health care services covered under this Policy include, but are not limited to:

1. Barrier methods, like diaphragms and sponges
2. Hormonal methods, like birth control pills and vaginal rings
3. Implanted devices, like intrauterine devices (IUDs)
4. Emergency contraception, like Plan B® and ella®
5. Female sterilization procedures
6. Patient education and counseling

Please note that oral contraceptives, contraceptive patches, diaphragms and contraceptive vaginal rings are covered under Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies) and male sterilization procedures are covered under Section 5. RR. (Covered Expenses / Surgical Services).

O. Dental Services

For oral surgery benefits, please see Section 5. RR. (Surgical Services).

1. Covered Dental Services:

   a. Any of the following health care services associated with dental repair or replacement of your teeth due to an injury if treatment begins within three months of the injury and is completed within 12 months of the injury (unless extenuating circumstances exist such as prolonged confinement or the presences of fixation wires from fracture care):

      1) Emergency examination
      2) Necessary diagnostic X-rays
      3) Endodontic (root canal) treatment
      4) Temporary splinting of teeth
      5) Prefabricated post and core
      6) Simple minimal restorative procedures (fillings)
      7) Extractions
      8) Post-traumatic crowns if such are the only clinically acceptable treatment
      9) Replacement of lost teeth due to the injury by implant, dentures or bridges

   b. Hospital or surgical center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to you in a hospital or surgical center if any of the following apply:

      1) You are a child under the age of five;
      2) You have a chronic disability that meets all of the following:

         a) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
         b) Is likely to continue indefinitely; and
c) Results in substantial limitations as determined by us in one or more of the following areas: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency.

3) You have a medical condition that requires confinement or a medical condition that requires general anesthesia for dental care.

c. 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.

2. Dental Services Exclusions:

a. The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

b. The general dental care and treatment of teeth, gums, or alveolar process including dentures, appliances, or supplies used in such care or treatment.

c. Injury or damage to teeth (natural or otherwise) caused by chewing food or similar substances.

d. Dental implants or other implant-related procedures, except as specifically stated in Paragraph 1. above.

e. Orthodontic treatment (e.g. braces).

f. Tooth extraction of any kind, except as specifically stated in Paragraph 1. above.

g. Periodontal care.

P. Diabetes Services

1. Covered Diabetes Services:

a. Purchase and installation of up to one insulin infusion pump per covered person per calendar year.

b. Continuous glucose monitor.

c. All other equipment and supplies used in the treatment of diabetes when they are dispensed by a health care provider other than a pharmacy. When insulin syringes and needles, lancets and lancet devices, diabetic test strips, alcohol pads, blood glucose monitors, auto injectors, and glucose control solution are dispensed by a pharmacy, benefits are payable according to Section 5. LL. (Prescription Legend Drugs and Supplies).

d. Medical eye exams (dilated retinal examinations).

e. Preventive foot care for covered persons with diabetes.

f. Diabetic self-management education programs.

2. Diabetes Services Limitation:

Insulin is not covered under this Section 5. P. For coverage of insulin, see Section 5. LL. (Prescription Legend Drugs and Supplies).

3. Diabetes Services Exclusion:

The Policy provides no benefit for the replacement of equipment unless medically necessary as determined by us. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

Q. Diagnostic Services

See Section 5. U. (Genetic Services) for benefits for genetic services.
1. **Covered Diagnostic Services:**

   The services must be directly provided to you and related to a covered physical illness or injury:
   
   a. Radiology (including x-rays and high-technology imaging)
   b. Laboratory services

2. **Diagnostic Services Exclusions:**

   The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   
   a. Charges for computer-aided detection (except for screening mammogram interpretation).
   b. Charges for imaging studies not for purposes of diagnosis (e.g. assisting in the design or manufacture of individualized orthopedic implants).

R. **Drug Abuse Treatment**

   See Section 5. G. (Behavioral Health Services) for benefits for the treatment of substance use disorders.

S. **Durable Medical Equipment**

   1. **Covered Durable Medical Equipment:**

      a. Rental or, at our option, purchase of durable medical equipment that is prescribed by a health care practitioner and needed in the treatment of an illness or injury.
      
      b. Subsequent repairs necessary to restore purchased durable medical equipment to a serviceable condition.
      
      c. Replacement of durable medical equipment if such equipment cannot be restored to a serviceable condition, subject to approval by us.
      
      d. Breastfeeding equipment in conjunction with each birth.
      
      e. Speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to illness or injury.

   2. **Durable Medical Equipment Limitations:**

      a. Benefits will be limited to the standard models, as determined by us.
      
      b. We will pay benefits for only one of the following: a manual wheelchair, a motorized wheelchair, a knee walker, or a motorized scooter, as determined by us.

   3. **Durable Medical Equipment Exclusions:**

      The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
      
      a. Rental fees that are more than the purchase price.
      
      b. Continuous passive motion (CPM) devices and mechanical stretching devices.
      
      c. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs, and cryotherapy; and home automated external defibrillator (AED).
      
      d. Durable medical equipment that we determine to have special features that are not medically necessary.
e. *Durable medical equipment* that we determine to be for your comfort, personal hygiene, or convenience including, but not limited to, physical fitness equipment, *health care practitioner’s* equipment, and self-help devices not medical in nature.

f. Routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of a one-month rental billed every six months.

g. Replacement of equipment unless we determine that it is *medically necessary*.

h. Replacement of over-the-counter batteries.

i. Repairs due to abuse or misuse as determined by us.

j. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which *benefits* are provided in Paragraph 1. above.

k. Blood pressure cuffs and monitors.

l. Enuresis alarms.

m. Trusses.

n. Ultrasonic nebulizers.

o. Oral appliances for snoring.

T. **Emergency Medical Care**

1. **Covered Emergency Medical Care:**
   a. *Emergency medical care* in an emergency room, as described below:
      
      1) *Benefits* are payable for *health care services* provided in an emergency room as shown in the Schedule of Benefits. If a *copayment* is shown, this *copayment* applies to the *emergency room visit*. We will waive the *emergency room visit copayment* if you are admitted as a resident patient to the *hospital* directly from the emergency room. If you are placed in *observation care* directly from the emergency room, the *emergency room visit copayment*, if applicable, will not be waived.

      2) 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 will be payable as stated in the Schedule of Benefits which applies to that hospital *confinement*.

   b. *Emergency medical care* received in a *health care practitioner’s* office, urgent care facility, or any place of service other than an emergency room will be payable as shown in the Schedule of Benefits.

2. **Emergency Medical Care Limitations:**
   a. If follow-up care or additional *health care services* are needed after the *medical emergency* has passed, such services from a *non-preferred provider* will be paid at the *non-preferred provider* level of benefits.

   b. If an ambulance service is called and you are transported to an emergency room, coverage for any *emergency medical care* directly provided to you during your ambulance transport is payable under Section 5. D. *(Covered Expenses / Ambulance Services)*. If an ambulance service is called, but you are not transported, *emergency medical care* provided to you will be payable under this Section 5. T., as shown in the Schedule of Benefits.

   c. Covered *health care services* received from a *non-preferred 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*. 

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U. Genetic Services

IMPORTANT NOTE: Genetic testing that we consider experimental/investigational/unproven will not be covered.

We may authorize genetic testing if the ordering health care provider shows that the results of such testing will directly impact your future treatment. Your health care practitioner 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, the ordering health care provider 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. We will not accept prior authorization requests from the laboratory that will perform the genetic services, unless there is supporting documentation from the ordering health care provider.

1. Covered Genetic Services:

   a. Genetic counseling provided to you by a health care practitioner, a licensed or Master’s trained genetic counselor or a medical geneticist;
   
   b. Amniocentesis during pregnancy;
   
   c. Chorionic villus sampling for genetic testing and non-genetic testing during pregnancy;
   
   d. Identification of infectious agents such as influenza and hepatitis. Panel testing for multiple agents is not covered unless your health care practitioner provides a justification for including each test in the panel;
   
   e. Compatibility testing for a covered person who has been approved by us for a covered transplant;
   
   f. Cystic fibrosis and spinal muscular atrophy testing as recommended by the American College of Medical Genetics;
   
   g. Molecular genetic testing of pathological specimens (such as tumors). All other molecular testing of blood or body fluids require prior authorization unless the test is otherwise specified on our website wpshealth.com. Please note that many molecular tumor profiling tests and gene-related or panel tests are not covered;
   
   h. BRCA testing for a covered person whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations and testing has been recommended after receiving genetic counseling. When such genetic counseling and testing is provided by a preferred provider, benefits are payable without cost-sharing; and
   
   i. All other genetic testing for which you receive our prior authorization.

2. Genetic Services Exclusions:

   a. The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   
   b. Genetic testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone.
   
   c. Genetic testing for conditions that cannot be altered by treatment or prevented by specific interventions.
   
   d. Genetic testing solely for the purpose of informing the care or management of your family members.
   
   e. Genetic testing that is not supported by documentation from the ordering health care provider.
   
   f. Genetic counseling performed by the laboratory that performed the genetic testing.
V. Health and Behavior Assessments

1. Covered Health and Behavior Assessments:
   a. Health and behavior assessments and reassessments
   b. Diagnostic interviews
   c. Neuropsychological testing

Please note that health and behavioral interventions provided by a psychologist pursuant to a health and behavior assessment are covered under Section 5. FF. (Medical Services).

2. Health and Behavior Assessments Exclusions:

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

   a. Intensive inpatient treatment by a psychologist to treat a medical condition.
   b. Baseline neuropsychological testing, for example, ImPACT® Immediate Post-Concussion Assessment and Cognitive Testing.

W. Hearing Aids, Implantable Hearing Devices, and Related Treatment

1. Covered Hearing Services:

Any of the following, provided you are certified as deaf or hearing impaired by a health care practitioner and that your hearing aids and/or devices are prescribed by a health care practitioner in accordance with accepted professional medical or audiological standards:

   a. One hearing aid (including fitting and testing), per ear, per covered person once every three years.
   b. Implantable hearing devices.
   c. Treatment related to hearing aids and implantable hearing devices covered under this Subsection W., including procedures for the implantation of implantable hearing devices.
   d. Post-cochlear implant aural therapy.

2. Hearing Services Exclusions:

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

   a. Hearing protection equipment.
   b. Hearing aid batteries and cords.

X. Home Care Services

This Section 5. X. applies only if charges for home care services are not covered elsewhere under the Policy.

1. Covered Home Care Services:

   a. Home safety evaluations, evaluations for a home treatment program, and/or initial visit(s) to evaluate you for an independent treatment plan.
   b. Part-time or intermittent home nursing care by, or under supervision of a registered nurse.
c. Part-time or intermittent home health aide services that consist solely of care for the patient as long as they are: (1) medically necessary; (2) appropriately included in the home care plan; (3) necessary to prevent or postpone confinement in a hospital or skilled nursing facility; and (4) supervised by a registered nurse or medical social worker.

d. Physical or occupational therapy or speech-language pathology or respiratory care.

e. Medical supplies, drugs and medications prescribed by a health care practitioner; and 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 confined in a hospital.

f. Nutrition counseling provided or supervised by a registered or certified dietician.

g. Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. Your attending health care practitioner must request or approve this evaluation.

2. Home Care Limitations:

a. 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, to evaluate your need for home care, or to develop 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.

b. 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.

3. Home Care Exclusions:

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Home care that is not ordered by a health care practitioner.

b. Home care provided to a covered person who is not confined to his/her home because of an illness or injury or because leaving his/her home would be contraindicated.

Y. Home Intravenous (IV) Therapy or Infusion Therapy

Intravenous (IV) therapy/infusion therapy prescribed by a health care practitioner and performed in your home, including but not limited to: (1) injections (intra-muscular, subcutaneous, continuous subcutaneous); (2) Total Parenteral Nutrition (TPN); and (3) antibiotic therapy.

Z. Hospice Care

1. Covered Hospice Care Services:

a. Hospice care services provided to you if you are terminally ill if: (1) 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.

b. Covered expenses for hospice care include:

1) Room and board at a hospice facility while you are receiving acute care to alleviate physical symptoms of your terminal illness;

2) Health care practitioner and nursing care; and

3) Services provided to you at your place of residence.
c. We will 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 health care practitioner certifies in writing that you are terminally ill.

2. Hospice Care Services Exclusions:

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Room and board for residential care at a hospital facility.

b. Hospice care services provided to you after the initial six-month period immediately following the diagnosis of a terminal illness, unless we have extended coverage per Paragraph 2. c. above.

AA. Hospital Services

Transplant services are not covered under this Section 5. AA. Please see Section 5. VV. (Transplants) for this coverage information. This Section 5. AA., does not include charges for outpatient physical, speech, or occupational therapy, please see Section 5. TT. (Therapy Services). Additionally, except for inpatient hospital services for detoxification, services for the treatment of substance use disorders and/or nervous or mental disorders are not covered under this Section 5. AA., please see Section 5. G. (Behavioral Health Services) for these coverage details.

1. Covered Hospital Services:

a. Inpatient Hospital Services. Benefits are payable for the following inpatient hospital services for a physical illness or injury:

   1) Charges for room and board.
   2) Charges for nursing services.
   3) Charges for miscellaneous hospital expenses.
   4) Charges for intensive care unit room and board.

b. Outpatient Hospital Services. Benefits are payable for miscellaneous hospital expenses, including services in observation care, for a physical illness or injury received by you while you are not confined in a hospital.

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

2. Hospital Services Limitations:

a. If you are confined in a hospital that is a non-preferred provider as an inpatient due to a medical emergency, we reserve the right to coordinate your transfer to a preferred provider once you are stable and can be safely moved.

b. If you are stable and refuse such transfer, further services from the non-preferred provider will not be covered at the preferred provider benefit level.

c. We will not cover inpatient stays at a hospital if care could safely and effectively be provided to you in a less acute setting.

BB. Infertility or Fertility Treatment

1. Covered Infertility or Fertility Treatment:

Health care services required to treat or correct underlying causes of infertility (e.g. blocked fallopian tube, endometriosis).
2. **Infertility or Fertility Treatment Exclusions:**

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. *Health care services* associated with expenses for *infertility*, including assisted reproductive technology, except for those services related to a covered medical condition.

b. Direct attempts to achieve pregnancy or increase chances of achieving pregnancy by any means.

c. Any laparoscopic procedure during which an ovum is manipulated for the purpose of *fertility treatment* even if the laparoscopic procedure includes other purposes.

CC. **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 a dialysis center.

Kidney transplantation services are payable under the organ transplant *benefit* in Section 5. VV. (Transplants).

DD. **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.

EE. **Maternity Services**

1. **Covered Maternity Services:**

a. Any of the following maternity services when they are provided by a *hospital* or *health care practitioner*:

   1) **Global maternity charge.** The global maternity charge is a unique procedure billed by a *health care practitioner* that includes prenatal care, delivery, and one postpartum care *office 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 *office visits* up to 28 weeks, biweekly *office visits* to 36 weeks, and weekly *office visits* until delivery are also included.

   2) **Charges** by a *hospital* 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.

b. With respect to *confinements* for pregnancy, the Policy will not limit the length of stay to less than: (i) 48 hours for a normal birth; and (ii) 96 hours for a cesarean delivery. However, a mother is free to leave the *hospital* earlier if she and her *health care practitioner* mutually agree to shorten the stay.

Kidney dialysis treatment may require prior authorization. See wpshealth.com.
2. **Maternity Exclusions:**

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Birthing classes, including Lamaze classes.

b. Abortion procedures, except as specifically stated in Paragraph 1.a. above.

c. Home births.

d. Continued hospital stay for the mother solely because her newborn infant remains confined in a hospital.

e. Continued hospital stay for the newborn infant solely because the mother remains confined in a hospital.

**FF. Medical Services**

1. Health and behavior interventions billed with a medical diagnosis.

2. *Medical services for a physical illness or injury*, including second opinions. Services must be provided in a hospital, health care practitioner’s office, urgent care center, surgical care center, convenient care clinic, or your home. *Medical services* covered under this Section 5. FF. do not include *health care services* covered elsewhere in the Policy, including *home care services* covered under Section 5. X. (Covered Expenses / Home Care Services).

**GG. Medical Supplies**

1. **Covered Medical Supplies:** *Medical supplies* prescribed by a health care practitioner, including but not limited to:

   a. Strapping and crutches

   b. Ostomy supplies limited to the following: pouches, face plates and belts; irrigation sleeves, bags and ostomy irrigation catheters; and skin barriers

   c. Disposable supplies, tubing, and masks for the effective use of covered durable medical equipment

2. **Medical Supplies Exclusions:**

   The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

   a. *Medical supplies* that we determine to be for your comfort, personal hygiene, or convenience including, but not limited to disposable supplies.

   b. Ostomy supplies that are not listed in Paragraph 1. above (such as deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover).

   c. Over-the-counter ace bandages, gauze and dressings.

   d. Compression stockings including those that you purchase from a durable medical equipment provider or pharmacy.

**HH. Nutritional Counseling**

Nutritional counseling that is: (1) for treatment of an illness or injury; and (2) provided by a health care practitioner, dietician or nutritionist licensed in the state where the counseling is provided to you. Nutritional counseling billed as educational services will not be covered, except as noted in Section 5. MM. (Preventive Care Services).
II. Orthotic Devices and Appliances

1. Covered Orthotic Devices and Appliances:
   a. Externally applied devices or appliances, including fittings and adjustments of custom-made rigid or semi-rigid supportive devices, that: (i) are used to support, align, prevent, or correct deformities; (ii) improve the function of movable parts of the body; or (iii) limit or stop motion of a weak or diseased body part.
   b. 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.
      3) Cervical collars;
      4) Orthoses (back braces); and
      5) Corsets (back and special surgical).
   c. Orthotic devices or appliances to support the foot are not covered unless they are a permanent part of an orthopedic leg brace.
   d. Orthotic devices or appliances may be replaced once per calendar year per covered person. The replacement must be medically necessary. Additional replacements will be allowed: (1) if you are under age 19 due to rapid growth; or (2) when a device or appliance is damaged and cannot be repaired.

2. Orthotic Devices and Appliances Limitation:
   Benefits will be limited to the standard models, as determined by us.

3. Orthotic Devices and Appliances Exclusions:
The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Routine periodic maintenance, such as testing, cleaning and checking of the device or appliance.
   b. Cranial banding or orthotic helmets, unless required after cranial surgery.

JJ. Pain Management Treatment
Pain management treatment including injections and other procedures to manage your pain related to an illness or injury.

KK. Palliative Care Services
   1. Covered Palliative Care Services:
      We will cover Palliative care that is otherwise a covered expense under the Policy.

LL. Prescription Legend Drugs and Supplies
   1. Covered Drugs.
      a. Any prescription legend drug not otherwise excluded or limited under the Policy.
      b. Any medicine a preferred 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/investigational/unproven or not medically necessary; if a compound drug contains non-covered ingredients, reimbursement will be limited to the covered prescription legend drug(s).
c. Preventive drugs that are obtained pursuant to a prescription order.

d. Injectable insulin.

e. 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.

f. An immunization that is not excluded elsewhere in the Policy.

g. Oral chemotherapy drugs.

h. Experimental/investigational/unproven drugs that are FDA approved administered according to protocol, and required by law to be covered.

2. Covered Supplies.

a. Insulin syringes and needles

b. Lancets and lancet devices

c. Formulary diabetic test strips

d. Alcohol pads

e. Formulary blood glucose monitors

f. Auto injector

3. Our Discretion. We have full discretionary authority to cover drugs or supplies that vary from the benefits described in the Policy if there is an advantage to both you and us.

4. Cost Sharing. See your Schedule of Benefits for information about copayments, deductibles, and coinsurance amounts that apply to drugs and supplies. You will have no applicable copayment, deductible, or coinsurance for any preventive drug. All other covered drugs and supplies are subject to any copayment, deductible, or coinsurance amounts listed in your Schedule of Benefits. If the preferred pharmacy’s charge is less than the copayment and/or deductible, you will only be responsible for the amount of the charge. Otherwise, you must pay any applicable copayment, deductible, and coinsurance amount for each separate prescription order or refill of a covered drug or covered supply.

5. Prescription Legend Drugs and Supplies Limitations.

a. Preferred Pharmacies. If drugs and supplies are dispensed to you by someone other than a preferred pharmacy, home delivery pharmacy, or specialty pharmacy you must pay for the drugs or supplies up front. To receive reimbursement, you must send us, or our delegate, a claim with 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 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 preferred pharmacy. You are responsible for the applicable copayment, deductible, or coinsurance and any difference between our benefit payment and the price you paid for the covered drug or supply.

b. Covered Drugs 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.

c. 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).

d. Prior Authorization. We have full discretionary authority to require prior authorization for certain drugs before they are eligible for coverage under the Policy. This applies to all prescription legend drugs, including
specialty drugs and drugs administered by a health care provider. To determine whether a drug requires prior authorization, visit wpshealth.com or call the telephone number shown on your identification card. If you do not receive prior authorization before receiving such drugs, benefits may not be payable under the Policy.

If a drug requires prior authorization, your health care practitioner must contact us, or our delegate, 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 delegate, 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 or is otherwise excluded under the Policy, no benefits will be payable for that drug.

e. **Use of Brand-Name Drugs When Lower Cost Equivalents Are Available.** If you obtain a brand-name drug and we determine that a lower cost equivalent drug (e.g. generic drug or biosimilar is available, you must pay the difference in cost between the drug obtained and its equivalent plus the applicable copayment, deductible, or coinsurance amount. The cost difference is not applied toward your out-of-pocket limit. Determination that a drug is equivalent must be supported by scientific evidence and/or determinations by regulatory entities such as the FDA.

For preventive drugs, coverage is also limited to generic drugs when they are available, with the exception of preventive contraceptive methods. If your health care practitioner submits proof to us that it is medically necessary for you to use a brand-name preventive contraceptive method instead of the equivalent generic preventive contraceptive method, we will cover the brand-name drug in full and you will not be charged.

However, we will cover a brand-name drug if substitution of an equivalent generic drug is prohibited by law.

f. **Quantity Limits.** The following quantity limits apply to all prescription legend drug benefits under this Subsection LL. We have full discretionary authority to 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 delegate, determine you are tolerating the specialty drug. In this case, your financial responsibility will be prorated.

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription legend drugs or supplies dispensed by a preferred pharmacy</td>
<td>Up to a 30-90 day supply per fill or refill</td>
</tr>
<tr>
<td>Prescription legend drugs (other than specialty drugs) or supplies dispensed by a home delivery pharmacy</td>
<td>Up to a 90-day supply per fill or refill</td>
</tr>
<tr>
<td>Preventive drugs used for Tobacco Cessation</td>
<td>180-day supply of nicotine replacement treatment (e.g., patches or gum) per covered person per 365-day period; and 180-day supply of another type of covered tobacco cessation drug (e.g., varenicline or bupropion) per covered person per 365-day period</td>
</tr>
<tr>
<td>Specialty drugs and biosimilar drugs</td>
<td>Up to a 30-day supply per fill or refill, except as noted above</td>
</tr>
<tr>
<td>Blood glucose monitor dispensed by a preferred pharmacy</td>
<td>One per covered person per calendar year</td>
</tr>
</tbody>
</table>

g. **Limitations on Covered Drugs and Covered 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, for example: (1) a preferred pharmacy where the drug can be obtained for self-administration; or (2) by a home care company, benefits for such prescription legend drugs purchased from and administered by a health care provider in a higher-cost place of service will not be covered. However, we have full discretionary authority to allow initial dose(s) of a drug to be administered by a health care provider in a higher-cost place of service in certain limited circumstances (for example teaching/training purposes).
6. **Prescription Legend Drugs and Supplies Exclusions.**

The Policy provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Any drug for which you do not have a valid *prescription order*.

b. Administration of a covered drug by injection or other means other than covered immunizations.

c. Refills of otherwise covered drugs that exceed the number your *prescription order* calls for.

d. Refills of otherwise covered drugs after one year from the date of the *prescription order*.

e. Drugs usually not *charged* for by the *health care provider*.

f. A drug that is completely administered at the time and place of the *health care provider* who dispenses it under the *prescription order*, except for immunizations and drugs for which you receive our *prior authorization*.

g. Anabolic drugs, unless we determine that they are being used for accepted medical purposes and eligible for coverage under the Policy.

h. Progesterone or similar drugs in any compounded dosage form, except for the purpose of maintaining a pregnancy under the appropriate standard of care guidelines.

i. Costs related to the mailing, sending or delivery of *prescription legend drugs*.

j. Refill of drugs, medicines, medications or *supplies* that are lost, stolen, spilled, spoiled, damaged, or otherwise rendered unusable.

k. Any drug or medicine that is available in prescription strength without a *prescription order*, except as determined by us.

l. More than one fill or refill for the same covered *supply*, covered drug or therapeutic equivalent medication prescribed by one or more *health care practitioner* 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 75% of the previous prescription.

m. *Charges* that are reduced by a manufacturer promotion (e.g., coupon or rebate);

n. Any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you.

o. Any compounded drug that is substantially like a commercially available product.

p. Any drug delivered to or received from a destination outside of the United States.

q. Any drug for which *prior authorization* is required but not obtained.

r. Any drug for which step therapy is required but not followed.

s. Non-legend vitamins, minerals, and supplements even if prescribed by a *health care practitioner*, except as specifically stated in the Policy.

t. All medicinal foods, enteral feedings, supplemental feedings, nutritional and electrolyte supplements, and infant formula.

u. Any drug or agent used for *cosmetic treatment*; for example, wrinkles or hair growth.

v. Any drug in unit-dose packaging except as required by law.
MM. Preventive Care Services

The following preventive care services are covered to the extent required by law. There is no cost sharing on preventive care services performed by a preferred provider.

1. Covered Preventive Care Services:

   a. Evidence-based health care services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF). The USPSTF may change its ratings during the year. See www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ for the current recommendations. Currently, the recommendations include:

      1) Routine medical exams, including hearing exams, pelvic exams, pap smears, and any related preventive care services, other than routine eye exams. Pelvic exams and pap smears are covered under this Paragraph 1. when directly provided to you by a health care practitioner.

      2) Routine medical exams, including hearing exams, and any related preventive care services directly provided to a covered child in connection with well-child care. Please see Section 5. XX. (Vision Services – Pediatric) for details regarding coverage of pediatric eye exams.

      3) One routine mammogram of a covered person per calendar year.

      4) Blood lead tests.

      5) Preventive screenings.

      6) 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.

      7) Annual counseling on sexually transmitted infections.

      8) Counseling for tobacco use.

      9) Prophylactic ocular topical medication for newborns against gonococcal ophthalmia neonatorum.

     10) Annual screening and counseling for covered persons for interpersonal and domestic violence.

     11) Healthy diet and physical activity counseling to prevent cardiovascular disease.

     12) Behavioral counseling for skin cancer.

   b. Other preventive care services that are provided on an outpatient basis at a health care practitioner’s office or hospital and that have been: demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease; and proven to have a beneficial effect on health outcomes. Such covered preventive care services include, but are not limited to, the following:

      1) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

      2) With respect to infants, children and adolescents, evidence-informed preventive care services and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

      3) With respect to women, such additional preventive care services and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

   c. Advanced care planning office consultations limited to one initial consultation and two follow-up consultations.

2. Preventive Care Services Limitation:

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

3. Preventive Care Services Exclusion:

This Policy provides no benefit for immunizations for travel purposes. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

NN. Prosthetics

1. Covered Prosthetics:

   a. Prosthetic devices and related 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.

   b. Covered prosthetic devices include, but are not limited to, artificial limbs, eyes, and larynx. Benefits are limited to one purchase no sooner than every three years of each type of the standard model, as determined by us.

   c. Replacement or repairs of prosthetics if we determine that they are medically necessary.

2. Prosthetics Exclusions:

   This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

   a. Prosthetics that we determine to have special features that are not medically necessary.

   b. Dental prosthetics.

   c. Repairs due to abuse or misuse.

OO. Pulmonary Rehabilitation

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.

PP. 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.

QQ. Skilled Nursing Care in a Skilled Nursing Facility

1. Covered Skilled Nursing Care:

   a. Skilled nursing care provided to you during the first 30 days of your confinement in a skilled nursing facility if: (1) you are admitted to a skilled nursing facility within 24 hours after discharge from a hospital or surgical center or directly from emergency room care, urgent care facility, or a health care practitioner’s office; and (2) you are admitted for continued treatment of the same illness or injury.
b. Each day of your confinement will count towards this 30-day limit, regardless of whether the charges are applied to your deductible or paid by WPS under the Policy.

c. Benefits are only payable for skilled nursing care which is certified as medically necessary by your attending health care practitioner every seven days.

2. Skilled Nursing Care Exclusions:

This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Skilled nursing care during a skilled nursing facility confinement if health care services can be provided at a lower level of care (e.g. home care or care in an outpatient setting).

b. Domiciliary care, such as meals-on-wheels, health visiting, and home help, provided by a welfare agency for people in their own homes.

c. Maintenance care, supportive care, or custodial care.

d. 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).

RR. Surgical Services

This Section 5. RR. does not include surgical services for: (1) covered transplants; (2) pain management procedures; or (3) behavioral health services. Please see Section 5. G. (Behavioral Health Services), Section 5. JJ. (Pain Management Treatment), and Section 5. VV. (Transplants) for this coverage information.

1. Covered Surgical Services:

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

a. Surgical services, other than reconstructive surgery and oral surgery. 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; and (b) arteriogram.

b. Reconstructive surgery when the primary purpose of the surgery is to correct functional impairment caused by an illness, injury, congenital abnormality, acute traumatic injury, dislocation, tumors, cancer, obstructive sleep apnea, or temporomandibular joint disorder. Please note that breast reconstruction following a mastectomy, reconstruction of the non-affected breast to achieve symmetry, and other services required by the Women’s Health and Cancer Rights Act of 1998 are covered under Section 5. DD. (Covered Expenses / Mastectomy Treatment).

c. Oral surgery, including related consultation, x-rays and anesthesia, limited to the excision of tumors and cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth, and orthognathic procedures.

d. Male sterilization procedures.

e. 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.

f. Congenital heart disease surgeries.

g. Removal of breast implants due to association with Anaplastic Large Cell Lymphoma.
2. Surgical Services Exclusions:
This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Incidental/inclusive surgical procedures that are performed in the same operative session as a major covered surgical procedure, which is the primary procedure. Benefits for incidental/inclusive 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 incidental/inclusive surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an incidental/inclusive surgical procedure; therefore, benefits are payable for the hysterectomy, but not for the removal of the appendix.

b. Reversal of a sterilization procedure.

c. Oral surgery, except as specifically stated in Paragraph 2. c. above.

d. Reconstructive surgery for purposes other than to correct functional impairment.

e. Any surgical service that we determine to be cosmetic treatment, except as otherwise indicated in the Policy.

f. Magnetic sphincter augmentation (Linx® System); transoral incisionless fundoplication procedures.

SS. Telemedicine

1. Covered Telemedicine Services:

a. Telemedicine services provided by a health care practitioner to a covered person via interactive audio-visual telecommunication to treat a covered illness or injury.

b. Telephone and interactive audio and video conferencing provided by our approved telehealth service providers. Visit https://wpshealth.com/resources/customer-resources/telehealth.shtml or call the Customer Service telephone number shown on your identification card for additional information about this benefit.

2. Telemedicine Exclusions:
This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Transmission fees.

b. Website charges for online patient education material.

TT. Temporomandibular Joint (TMJ) Disorder Services

1. Covered TMJ Disorder Services:

a. Diagnostic procedures, surgical services and non-surgical treatment for the correction of TMJ disorders if all of the following apply:

1) The disorder is caused by congenital, developmental or acquired deformity, illness or injury;

2) Under the accepted standards of the profession of the health care practitioner 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.
b. Non-surgical treatment includes coverage for prescribed intraoral splint therapy devices.

2. TMJ Services Disorder Exclusions:

This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Elective orthodontic care, periodontic care or general dental care.

b. Health care services provided in connection with the temporomandibular joint or TMJ disorder, except as specifically stated in Paragraph 1. above.

UU. Therapy Services

1. Therapy Limitations:

a. Outpatient therapy is, limited as follows:

1) Physical therapy is limited to 20 therapy visits per covered person per calendar year when billed as rehabilitative services and 20 therapy 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. Aquatic therapy is covered only when the therapy is billed by a physical therapist or occupational therapist;

2) Speech therapy is limited to 20 therapy visits per covered person per calendar year when billed as rehabilitative services and 20 therapy visits per calendar year when billed as habilitative services; and

3) Occupational therapy is limited to 20 therapy visits per covered person per calendar year when billed as rehabilitative services and 20 therapy visits per calendar year when billed as habilitative services.

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

c. All therapy must be expected to provide significant measurable gains that will improve your physical health.

d. All therapy must be performed by a health care practitioner excluding a massage therapist. If a license to perform such therapy is required by law, that therapist must be licensed by the state in which he/she is located and must provide such therapy while he/she is acting within the lawful scope of his/her license.

2. Therapy Exclusions:

This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Physical therapy for TMJ disorders, except as specifically stated in Section 5. TT. (Temporomandibular Joint (TMJ) Disorder Services).

b. Long-term therapy and maintenance therapy, except as specifically stated in Paragraph 1. above.

VV. Transplants

1. Prior Authorization and Cost-Sharing Requirements:

a. All transplant services require prior authorization. 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 criteria for medically necessary transplants and may not be experimental/ investigational/unproven.

b. If prior authorization is obtained, we will pay benefits for charges for covered expenses you incur at a designated transplant facility or non-
designated transplant facility as determined by us during the prior authorization process for an illness or injury.

c. Transplant services are subject to any deductibles, coinsurance, or limits shown in the Schedule of Benefits.

2. Covered Transplants:

a. We will cover approved transplant services, including but not limited to organ and tissue acquisition and transplantation, including any post-transplant complications, if you are the recipient; and related medical care, including any post-harvesting complication, if you are a donor.

b. 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 Section 5. LL. (Prescription Legend Drugs and Supplies).

c. Benefits are payable for any transplant approved by us, including, but not limited to:

1) Kidney
2) Kidney/pancreas
3) Liver
4) Heart
5) Heart/lung
6) Lung
7) Bone marrow (allogenic and autologous)
8) Stem cell transplants
9) Small bowel transplantation
10) Cornea
11) Artificial or mechanical devices, if approved as a bridge to transplant or destination therapy

3. Transplant Exclusions:

This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Transplants considered by us to be experimental/investigational/unproven.

b. Expenses related to the purchase of any organ.

c. Health care services for, or used in connection with, transplants of human and non-human body parts, tissues or substances, or implants of artificial or natural organs, except as specifically stated in Paragraph 2. above.

d. Lodging expenses, including meals, unless such expenses are covered under the global fee agreement of your transplant network.
WW. Vision Services - Non-Routine

Please note that vision services for children under the age of 19 are covered in Section 5. XX. (Covered Expenses / Vision Services – Pediatric).

1. Covered Non-Routine Vision Services:
   a. Diagnosis and treatment of eye pathology.
   b. Eye surgery to treat an illness or injury to the eye.
   c. Initial pair of eyeglasses or external contact lenses for keratoconus.

2. Vision Services Exclusions:
   This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Vision therapy;
   b. Refractive eye surgery, such as radial keratotomy;
   c. Orthoptic therapy and pleoptic therapy (eye exercise);
   d. Preparation, fitting or purchase of eyeglasses or contact lenses, except as specifically stated in the Policy;
   e. Correction of visual acuity or refractive errors by any means, except as specifically stated in the Policy;
   f. Implantable specialty lenses, including, but not limited to, toric astigmatism-correcting lenses and multifocal presbyopia-correcting intraocular lenses to improve vision following cataract surgery;
   g. Replacement lenses, frames, or contact lenses due to loss, theft, or damage; and
   h. Routine eye exams, except as specifically stated in the Policy.

XX. Vision Services - Pediatric

1. Pediatric vision services as listed below for a covered person until the last day of the month in which he/she reaches age 19:
   a. Routine eye exams, including refractions.
   b. 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.
   c. 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.
   d. Contact lenses when purchased in lieu of all other frames and/or lenses. Benefits are limited to 48 contact lenses per covered person per calendar year.

2. The following services, provided you receive our prior authorization:
   a. Contact lenses for the following conditions:
      1) Pathological myopia;
      2) Anisometropia;
      3) Aniseikonia;
      4) Aniridia;
5) Corneal disorders;
6) Post-traumatic disorders; and
7) Irregular astigmatism.

b. Low vision services including the following:
   1) One comprehensive low vision evaluation every five years;
   2) Low vision aids, limited to the following: (a) spectacles; (b) magnifiers; and (c) telescopes; and
   3) Follow-up care of four visits in any five-year period.

c. The following lens options and treatments:
   1) Ultraviolet protective coating;
   2) Blended segment lenses;
   3) Intermediate vision lenses;
   4) Standard progressives;
   5) Premium progressives;
   6) Photochromic glass lenses;
   7) Plastic photosensitive lenses;
   8) Polarized lenses;
   9) Standard anti-reflective coating;
   10) Premium anti-reflective coating;
   11) Ultra anti-reflective coating; and
   12) Hi-index lenses.

6. GENERAL EXCLUSIONS

The Policy provides no benefits for any of the following:

1. Health care services that we determine are not medically necessary.

2. Health care services that we determine are experimental/investigational/unproven, except for the following, which are covered under the Policy as described in Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies):
   a. Investigational drugs for the treatment of HIV infection as described in Wis. Stat. § 632.895(9); and
   b. Drugs that by law require a written prescription used in the treatment of cancer that may not currently have the FDA’s approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis.

3. Maintenance care or supportive care.

4. Health care services that we determine to be cosmetic treatment, except as otherwise provided in the Policy.

5. Health care services provided in connection with any injury or illness arising out, 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. This exclusion applies regardless of whether benefits under workers’
compensation laws or any similar laws have been claimed, paid, waived, or compromised. See Section 10. M. (General Provisions / Worker’s Compensation) for additional information.

6. **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.

7. **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.

8. The amount of benefits that are covered by Medicare as the primary payer if you are enrolled in Medicare. See Section 7. H. (Coordination of Benefits / Coverage with Medicare) for additional information.

9. **Health care services** for any illness or injury caused by war or act(s) of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to **covered persons** who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

10. **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 being on active duty in the armed services of any country.

11. **Custodial care**, except **home health aide services** as covered in Section 5. X. (Covered Expenses / Home Care Services).

12. **Charges** in excess of the **maximum allowable fee** or **maximum out-of-network allowable fee**.


14. **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.

15. Completion of forms, including but not limited to claim forms or forms necessary for the return to work or school.

16. An appointment you did not attend.

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** related to a non-covered health care service. When a service is not a covered health care service, all services related to that non-covered health care service are also excluded. This exclusion does not apply to services we would otherwise determine to be a covered health care services if they are to treat complications that arise from the non-covered health care service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing illness and that affects or modifies the prognosis of the original illness. Examples of a "complication" are bleeding or infections, following cosmetic treatment, which requires confinement in a hospital.

19. **Health care services** requested or required 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. Private duty nursing.

21. Transportation or other travel costs associated with a health care service, except as specifically provided in Section 5. D. (Covered Expenses / Ambulance Services).

22. **Health care services** that are excluded elsewhere in the Policy.

23. **Health care services** not specifically identified as being covered under the Policy, except for those health care services approved by us subject to Section 5. C. (Covered Expenses / Alternative Care).

24. **Health care services** provided when your coverage was not effective under the Policy. Please see Section 2. (Eligibility, Enrollment, and Effective Date) and Section 8. (When Coverage Ends).

25. **Health care services** not provided by a health care practitioner or any of the health care providers listed in Section 5. (Covered Expenses).
26. 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. Augmentation mammoplasty (except for reconstruction associated with a covered mastectomy);
   j. Correction of inverted nipples;
   k. Sclerotherapy or other treatment for varicose veins less than 3.5 millimeters in size (e.g., telangiectasias, spider veins, reticular veins);
   l. Excision or elimination of hanging skin on any part of the body, such as panniculectomy; abdominoplasty and brachioplasty;
   m. Mastectomy for 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;
   q. Treatment of sialorrhea (drooling or excessive salivation); and
   r. Medical services and surgical services for the treatment of excessive sweating (hyperhidrosis).

27. Health care services provided at any nursing facility or convalescent home or charges billed by any place that is primarily for rest, the aged, or the treatment of substance use disorders, except as specifically stated in Section 5. G. (Covered Expenses / Behavioral Health Services).

28. 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 health care services that are associated with a medical diagnosis of diabetes, peripheral vascular disease or peripheral neuropathy.

29. Housekeeping, shopping, or meal preparation services.

30. 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.

31. Health care services for which proof of claim isn't provided to us as required by the Policy.

32. Health care services not for or related to an illness or injury, other than as specifically stated in the Policy.

33. Sales tax or any other tax, levy, or assessment by any federal or state agency or local political subdivision.

34. Costs associated with indirect services provided by health care providers such as: creating standards, procedures, and protocols; calibrating equipment; supervising testing; setting up parameters for test results; reviewing quality
assurance data; transporting lab specimens; concierge payments; translating claim forms or other records; and after-hours charges.

35. *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.

36. *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) penile implants; and (d) sex therapy.

37. Storage of blood tissue, cells, or any other body fluids.

38. Salivary hormone testing.

39. *Health care services* performed while outside of the United States, except in the case of a *medical emergency*.

40. Prolotherapy.

41. Platelet-rich plasma.

42. Coma stimulation/recovery programs.

43. Environmental items including, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

44. Wigs, toupees, hairpieces, cranial prosthesis, hair implants, or transplants or hair weaving, or hair loss prevention treatments.

45. Car seats.

46. 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, and ramps.

47. *Health care services* used in educational or vocational training or testing.

48. Medications for which the primary purpose is to preserve fertility.

49. *Health care services* for holistic, complementary, alternative 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, reflexology, and programs with an objective to provide personal fulfillment.

50. Hypnosis.

51. Acupuncture.

52. Biofeedback, except for fecal/urinary incontinence.

53. Therapy services such as recreational therapy (other than recreational therapy included as part of a *treatment* program received during a *confinement* for *treatment* of *nervous or mental disorders* and/or *substance use disorders*), educational therapy, physical fitness, or exercise programs, except as specifically stated in Sections 5, 1. (Covered Expenses / Cardiac Rehabilitation Services) and 5. TT. (Covered Expenses / Therapy Services).

54. Photodynamic therapy and laser therapy for the *treatment* of acne.

55. Vocational or industrial rehabilitation including work hardening programs.

56. Sports hardening and rehabilitation.

57. *Health care services* that are solely for educational, occupational or athletic purposes and not for *treatment* of an *illness* or *injury*.

58. General fitness programs, exercise programs, exercise equipment, health club or health spa fees, personal trainers, aerobic and strength conditioning, functional capacity exams, physical performance testing, and all material and products related to these programs.
59. Health care services provided in connection with a diagnosis of obesity, weight control, or weight reduction, regardless of whether such services are prescribed by a health care practitioner or associated with an illness or injury, except as indicated in Section 5. MM. (Covered Expenses / Preventive Care Services). Services excluded under this provision include, but are not limited to:

a. Gastric or intestinal bypasses;
b. Gastric balloons or banding;
c. Stomach stapling;
d. Wiring of the jaw;
e. Liposuction;
f. Any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you;
g. Weight loss programs and nutritional counseling, unless benefits are provided elsewhere in the Policy;
h. Physical fitness or exercise programs or equipment, unless benefits are provided elsewhere in the Policy; and
i. Bone densitometry (DEXA, DXA) scans.

60. Health care services performed by a health care practitioner who is a family member by birth, marriage or domestic partnership. Examples include a spouse, domestic partner, brother, sister, parent or child. This includes any health care service the provider may perform on himself or herself.

61. Health care services performed by a health care practitioner with your same legal residence.

62. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

63. Respite care. Except respite care that is part of hospice care as described under Section 5. Z. (Covered Expenses / Hospice Care).

7. COORDINATION OF BENEFITS (COB)

A. Definitions

The following definitions apply to this Section 7. 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 will 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 the Policy or any part of a year before the date this Section 7. or a similar provision takes effect.

3. 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 Paragraphs 3. 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.

4. **Primary Plan/Secondary Plan:** Subsection C. (Order of Benefit Determination Rules) below states whether the Policy is a primary plan or secondary plan as to another plan covering the person. When the Policy is a primary plan, its benefits are determined before those of the other plan and without considering the other plan’s benefits. When the Policy 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, the Policy 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.

B. **Applicability**

1. This Section 7. applies when you have health care coverage under the Policy and another plan.

2. If this Section 7. applies, the order of benefit determination rules will be looked at first. The rules determine whether the benefits of the Policy are determined before or after those of another plan. The benefits of the Policy:

   a. Will not be reduced when, under the order of benefit determination rules, the Policy 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 D. (Effect on the Benefits of the Policy) below.

C. **Order of Benefit Determination Rules**

1. When there is a basis for a claim under the Policy and another plan, the Policy is a secondary plan unless:

   a. The other plan is automobile medical expense benefit coverage or has rules coordinating its benefits with those of the Policy; and

   b. Both those rules and the Policy's rules described in Paragraph 2. below require that the Policy’s benefits be determined before those of the other plan.

2. The Policy 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 Paragraph 2. c. below, when the Policy and another plan cover the same child as a dependent of different persons, called “parents”, 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 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 above 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 will 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 or domestic partner 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 will 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 will be determined according to Paragraph 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 2. c. 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 Paragraph 2. 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 will supersede this Paragraph 2. d.

e. Continuation Coverage. If a person has continuation coverage under federal or state law and is also covered under another plan, the following will determine the order of benefits:

1) 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;

2) Second, the benefits under the continuation coverage; and

3) If the other plan does not have the rule described in Subparagraph 1) and 2), and if, as a result, the plans do not agree on the order of benefits, this Paragraph 2. 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, subscriber or dependent longer are determined before those of the plan which covered that person for the shorter time.

g. None of the Above. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans meeting the definition of plan under this provision. In addition, the Policy will not pay more than it would have paid had it been the primary plan.

D. Effect on the Benefits of the Policy

1. When This Subsection Applies. This Subsection D. applies when, in accordance with Subsection C. (Order of Benefit Determination Rules), the Policy is a secondary plan as to one or more other plans. In that event, the benefits of the Policy may be reduced under this Subsection D. Such other plan or plans are referred to as “the other plans” below.

2. Reduction in the Policy's Benefits. The benefits of the Policy 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 the Policy 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 a claim is made. Under this provision, the benefits of the Policy 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 the Policy are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Policy.

E. 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 the Policy must give us any facts we need to pay the claim.

F. Facility of Payment

A payment made under another plan may include an amount which should have been paid under the Policy. 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 the Policy. 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.

G. Right of Recovery

1. If the amount of the payments we made is more than we should have paid, we may recover the excess from one or more of:
   a. The persons we paid or for whom we paid;
   b. Insurance companies; or
   c. Other organizations.

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

H. Coverage with Medicare

If you or a covered dependent are receiving benefits under both this Policy and Medicare, federal law may require this Policy to be primary over Medicare. For example, this Policy will pay as the primary plan and Medicare will pay as the secondary plan under the following circumstances:

1. If 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. If the covered person is: under age 65; covered under an employer group health plan of an employer with at least 100 employees because he/she or a covered family member is working as an employee, is the employer (including self-employed persons) or is an individual associated with the employer in a business relationship; and receiving Medicare benefits due to his/her 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.

3. If the 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 the secondary plan for 30 months from entitlement to, or eligibility for, Medicare based on ESRD.

When this Policy is not primary, this Policy will coordinate benefits with Medicare in accordance with federal law.

Per Section 6. (General Exclusions), Paragraph 8., if you are enrolled in Medicare as your primary plan, this Policy will not cover any expense that Medicare would cover.

If the covered person (employee or the employee’s spouse) is eligible but not enrolled in Medicare, this Policy will pay benefits as described in this employer group health plan.
8. WHEN COVERAGE ENDS

A. General Rules

We may terminate your coverage under the Policy at 11:59 p.m. on the earliest of the following dates:

1. The date the Policy terminates.
2. The day in which you die.
3. 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 an assignment of less than 30 days.
5. The last day of the calendar month in which the subscriber’s employment terminates.
6. The last day of the calendar month in which we determine the subscriber no longer meets the definition of eligible employee. However, the employee’s coverage under the Policy may continue if the subscriber is:
   a. 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 subscriber’s coverage will continue until the last day of the calendar month in which we determine the subscriber fails to return to work from that leave of absence;
   b. Granted a leave of absence under the policyholder’s established leave of absence policy. In this case, the subscriber’s coverage will continue no longer than three consecutive months. Such leave of absence policy and any supporting documentation must be provided to us upon our request; or
   c. Subject to a collective bargaining agreement (CBA). In this case, the subscriber’s coverage will continue as stated in the CBA. The CBA 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 last day of the month in which we receive the policyholder’s request to terminate a covered person’s coverage, unless the policyholder specifies a later coverage termination date.

8. For a subscriber’s covered dependent, the date the subscriber’s coverage terminates under the Policy.

9. For a subscriber’s spouse or domestic partner who is a covered person: (a) the day the subscriber’s spouse is no longer married to the subscriber due to divorce or annulment; or (b) the day the domestic partner no longer meets the definition of eligible dependent.

10. For a child who is a covered dependent, the earliest of the following dates, as determined by us:
   a. 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 he/she qualifies as an eligible dependent due to his/her disability (see the definition of eligible dependent in Section 14. (Definitions));
   b. For step-children, the date the subscriber’s spouse is no longer married to the subscriber; or
   c. For a child of a domestic partner, the date the subscriber’s domestic partner no longer meets the definition of an eligible dependent.

11. For a child of a covered dependent child (i.e. the subscriber’s grandchild), the date the subscriber’s child reaches age 18.

12. For any covered dependent, the last day of the calendar month in which the individual no longer meets the definition of eligible dependent.
It is the subscriber’s responsibility to notify the policyholder of his/her covered dependent losing status as an eligible dependent. If he/she does not so notify the policyholder, the subscriber will be responsible for any claim payments made during the period of time the covered dependent was not an eligible dependent.

**B. 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 that the leave of absence is medically necessary from his/her attending health care practitioner.

Coverage will 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 on which he/she ceased to be a full-time student due to the medically necessary leave of absence if he/she has not returned to school on a full-time basis.

It is the subscriber’s responsibility to notify us of his/her child losing status as an eligible dependent. If he/she does not so notify us, the subscriber will be responsible for any claim payments made on behalf of the child while he/she was not an eligible dependent.

**C. Special Rules for Disabled Children**

If you have family coverage under the Policy, a child may continue coverage under your family coverage beyond the limiting age if: (1) the child’s coverage under the Policy began before he/she reached age 26; (2) the child is incapable of self-sustaining employment because of intellectual disability or physical handicap; (3) the child is chiefly dependent upon the subscriber for support and maintenance; (4) the child’s incapacity existed before he/she reached age 26; and (5) the subscriber’s family coverage remains in force under the Policy.

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 will result in the termination of that child’s coverage. After the child turns 28, we may request proof of disability annually.

It is the subscriber’s responsibility to notify us if his/her child no longer qualifies as an eligible dependent. If he/she does not so notify us, the subscriber will 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.

**D. Extension of Benefits**

This Section 8. D. 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 Wis. Admin. Code Ins 6.51 (6) and (7) require that we provide an extension of coverage.

1. **Conditions That Trigger an Extension of Benefits.**

   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:

   a. Totally disabled; or
   
   b. Confined in a hospital.
An extension of benefits provided under this Subsection D. will 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.

An extension of benefits under this Section 8.D. does not provide coverage for dental services, uncomplicated pregnancies or for any injury or illness other than the covered illness or injury causing the covered person’s total disability or confinement.

E. 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 an individual other than a 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.

9. CONTINUATION COVERAGE

A. Wisconsin Law

1. In certain cases, you may be eligible to continue coverage that would otherwise end under Section 8. (When Coverage Ends) in accordance with Wis. Stat. § 632.897. Those who are eligible to purchase continuation coverage are:
   a. Subscribers who are no longer eligible for coverage under the Policy through the policyholder, except if their employment is terminated for misconduct; or
   b. A subscriber's covered dependent who is no longer eligible for coverage under the Policy through the policyholder due to divorce, annulment or death of the subscriber. 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.

2. Within five days of the policyholder’s receiving notice to end your coverage or notice that you are eligible under Paragraphs 1. a. or 1. b. above, the policyholder must notify you of:
   a. Your option to continue your coverage;
   b. 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;
   c. The manner in which and the place to which you must make premium payments; and
   d. The time by which you must pay the premiums required for continuation coverage.

3. 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:
a. The date you become eligible for other similar group health care coverage or the same coverage under the Policy;
b. For a subscriber's former spouse, the date the subscriber is no longer eligible for coverage under the Policy;
c. The date the Policy terminates;
d. The date you move out of Wisconsin;
e. The end of the last coverage period for which you paid the required premium; or
f. 18 consecutive months after you elect continuation coverage.

4. 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.

5. 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 9. A. provides, or will 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.

B. 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 children who qualify as eligible dependents, 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 status as an eligible dependent 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.

10. GENERAL PROVISIONS

A. Your Relationship with Your Health Care Practitioner, Hospital or Other Health Care Provider

We won't interfere with the professional relationship you have with your health care practitioner, hospital or other health care provider. We do not require that you choose any particular health care practitioner, hospital, or other health care provider, although there may be different benefits payable under the Policy depending on your choice of health care practitioner, hospital, or other health care provider. We do not guarantee the competence of any particular health care practitioner, hospital, other health care provider or their availability to provide services to you. You must choose the health care practitioner, hospital, or other health care provider you would like to see and the 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 health care practitioner, hospital, or other health care provider, including, but not limited to, any preferred provider. We're obligated only to provide the benefits as specifically stated in the Policy.

B. Your Right to Choose Medical Care

The Policy does not limit your right to choose your own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, you still have the right and privilege to receive such health care service at your own personal expense.
C. **Health Care Practitioner, Hospital or Other Health Care Provider Reports**

1. *Health care practitioners, 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:

   a. *Any health care provider* who has diagnosed, attended, treated, advised or provided *health care services* to you;

   b. *Any hospital* or other health care facility in which you were treated or diagnosed; and

   c. *Any other insurance company, service, or benefit plan* that possesses information that we need to determine your *benefits* under the Policy.

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

D. **Assignment of Benefits**

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

E. **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 will:

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. Not do anything before or after our payment that would prejudice our rights.

Our right to subrogate will 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*.
F. 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 have received the claim described in Section 11. A. (Claim Filing and Processing Procedures / Filing Claims); or (2) the date we deny payment of benefits for a claim. This provision does not apply if waiting will result in loss or injury to 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 claim filing deadline outlined in Section 11. A. (Claim Filing and Processing Procedures / Filing Claims).

G. Severability

Any term, condition or provision of the Policy that is prohibited by Wisconsin law will 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 will be interpreted in a way that achieves the original intent of the parties as closely as possible.

H. 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 will automatically conform to the minimum requirements of such laws and regulations.

I. 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 will send written notice of the change to the policyholder at least 60 days before it takes effect.

Any change to the Policy will be made by an endorsement signed by our Chief Executive Officer. Each endorsement will be binding on the policyholder, all covered persons, and us. No error by us, the policyholder, or any covered person will: (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 have full discretionary authority to make an equitable adjustment of coverage, payment of benefits, and/or premium.

J. Refund Requests

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

K. Quality Improvement

The WPS 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 preferred providers and WPS staff guide, direct, and evaluate quality initiatives. Preferred 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 care services and to improve management of acute and chronic diseases. The Quality Improvement Committee is responsible for directing the process of improvement efforts.
L. **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**
   a. You have the right to receive quality health care that is friendly and timely.
   b. You have the right to be treated with respect and recognition of your dignity and right to privacy.
   c. You have the right to receive all *medically necessary* covered services when your *health care providers* feel they are needed.
   d. You have the right to a candid discussion of appropriate or *medically necessary treatment* options for your conditions, regardless of cost or *benefit* coverage.
   e. You have the right to refuse treatment.
   f. You have the right to participate with *health care providers* in making decisions about your health care.
   g. You have the right to all information contained in your medical records.
   h. 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.
   i. 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.
   j. You have the right to have your medical and financial records kept private.
   k. You have the right to voice complaints or appeals about us or the health care coverage we provide.
   l. You have the right to have a resource at WPS that you can contact with any concerns about services and to receive a prompt and fair review of your complaint.
   m. You have the right to make recommendations regarding the member rights and responsibilities policies.

2. **Your Responsibilities as a Health Plan Member**
   a. You have the responsibility to select a *health care practitioner* and to communicate with him or her in order to develop a patient-*health care practitioner* relationship based on trust, respect, and cooperation.
   b. You have the responsibility to know your health plan *benefits* and requirements.
   c. You have the responsibility to coordinate all non-life-threatening care through your *health care practitioners*.
   d. 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.
   e. You have the responsibility to supply information (to the extent possible) that *health care providers* need in order to provide care and that we need in order to provide coverage.
   f. You have the responsibility to understand your health problems and to participate in developing mutually agreed-upon *treatment* goals to the degree possible.
   g. You have the responsibility to follow the treatment plan and instructions for care that have been agreed on with your *health care practitioners*.
   h. You have the responsibility to give proof of coverage each time you receive services and to update your clinic with any personal changes.
i. You have the responsibility to pay copayments when you receive services and to promptly pay deductibles, coinsurance, and other charges for services not covered by the Policy.

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

M. Workers’ Compensation

The Policy 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, and for which benefits are provided or payable under any workers’ compensation or occupational disease act or law, are excluded from coverage under the Policy. If a covered person receives benefits under the Policy 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 will 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;

3. The medical or health care benefits are specifically excluded from the workers’ compensation settlement or compromise; or

4. The workers’ compensation settlement or compromise purports to be limited to lost wages or other recovery other than medical expenses.

N. Written Notice

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

11. CLAIM FILING AND PROCESSING PROCEDURES

A. Filing Claims

1. How to File a Claim

Either you or your health care provider must submit the following information to us within 90 days after receiving a health care service:

a. A fully-completed claim form, including all of the following information:

1) Subscriber name;

2) Subscriber number;

3) Provider name;

4) Provider address;

5) Provider Tax ID or National Provider Identifier (NPI) Number;

6) Patient’s name;

7) Patient’s date of birth;

8) Date of service;

9) Procedure code;
10) Diagnosis code; and

11) Billed charges for each service.

b. If all sections of the claim form are not completed in full, your claim may be returned to you.

c. 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 translated 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.

Unless otherwise specifically stated in the Policy, we have the option of paying benefits either directly to the health care provider or to you. Payments for covered expenses for which we are liable may be paid under another group or franchise plan or policy arranged through your employer, trustee, union or association. In that case, we can discharge our liability by paying the organization that has made these payments. In either case, such payments will fully discharge us from all further liability to the extent of benefits paid.

2. Exception to 90-Day Claim Filing Deadline

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. Pharmacy Prescription Claims

Prescription legend drug claims made after 4:00 PM will be logged in and handled on the next business day.

4. How to Appeal a Claim Denial

If a claim is denied, you may appeal the denial by filing a written grievance. Please see Section 12. (Internal Grievance and Appeal Procedures) for more information.

B. Designating an Authorized Representative

You may designate an authorized representative to pursue a claim for benefits or a grievance on your behalf. Such authorized representative will be treated as if he/she is the covered person and we will send our written decision responding to the claim for benefits or grievance to the authorized representative, not you. This written decision will contain personal information about you, including your confidential medical information, if any, that applies to the matter in which you designated the authorized representative to act on your behalf.

No person will be recognized as an authorized representative until we receive written documentation of the designation, on a form approved by us, unless the claim is an urgent claim. An assignment for purposes of payment does not constitute designation of an authorized representative under these claims procedures. Designation of an authorized representative does not constitute assignment for purposes of payment.

In instances of an urgent claim, we will recognize a health care professional with knowledge of your medical condition as your authorized representative unless you specify otherwise.

If you have an authorized representative, any references to “you” or “your” in this Section 11. will refer to the authorized representative.
C. Claim Processing Procedure

Benefits payable under the Policy will be paid after receipt of a correctly filed claim or prior authorization request as follows:

1. **Concurrent Care Decisions.** We will notify you of a concurrent care decision that involves a reduction in or termination of benefits prior to the end of any prior authorization for a course of treatment. 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.

A request to extend a prior authorization of treatment that involves urgent care must be responded to as soon as possible, taking into account medical urgency. We will notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of your request provided that the request is submitted to us at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

2. **Urgent Claims.** We will notify you of our decision on your claim within 72 hours of receipt of an urgent 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.

We will determine whether a submitted claim is an urgent claim. This determination will be made on the basis of information provided by or on behalf of you. In making this determination, we will exercise our judgment with deference to the judgment of a health care practitioner with knowledge of your condition. As a result, we may require you to clarify the medical urgency and circumstances that support the urgent claim for expedited decision-making.

If the claim is an incorrectly filed claim, we will notify you of the failure to follow the proper procedures as soon as possible, but not later than 24 hours following receipt of the incorrectly filed claim. Such notification will explain the reason why the request failed and the proper procedures for filing an urgent pre-service claim.

If the claim is an incomplete claim, we will notify you of the specific information needed as soon as possible, but no later than 24 hours after we receive the incomplete claim. You will then have 48 hours from the receipt of the notice to provide us with the requested information. We will notify you of our decision as soon as possible, but not later than 48 hours after the earlier of: (a) our receipt of the additional information; or (b) the end of the period of time provided to submit the additional information.

3. **Pre-Service Claims.** If your pre-service claim involves experimental/investigative/unproven treatment, we will notify you of our decision on your claim as soon as possible, but not later than 5 business days after we receive it.

For all other pre-service claims, we will notify you of our decision on your claim as soon as possible, but not later than 15 days after our receipt of a pre-service claim. However, this period may be extended one time by an additional 15 days if we determine that an extension is necessary due to matters beyond our control. We will notify you of the extension prior to the end of the initial 15-day period, the circumstances requiring the extension, and the date by which we expect to make a decision.

If the claim is an incorrectly filed claim, we will notify you of the failure to follow the proper procedures as soon as possible, but not later than 5 days following receipt of the incorrectly filed claim. Such notification will explain the reason why the request failed and the proper procedures for filing a pre-service claim.

If the claim is an incomplete claim, we may extend this time by an additional 15 days, provided that we notify you that an extension is necessary and of the specific information needed prior to the end of the initial 15-day period. You will then have 45 days from the receipt of the notice to provide us with 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.
4. **Post-Service Claims.** We will notify you of our decision on your claim as soon as possible, but not later than 30 days after our receipt of a post-service claim.

However, this period may be extended one time by an additional 15 days if we determine that an extension is necessary due to matters beyond our control. We will notify you of the extension prior to the end of the initial 30-day period, the circumstances requiring the extension, and the date by which we expect to make a decision.

If the claim is an incomplete claim, we may extend this time by an additional 15 days, provided that we notify you that an extension is necessary and of the specific information needed prior to the end of the initial 30-day period. 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.

**D. Claim Decisions**

If benefits are payable on charges for services covered under the Policy, we will pay such benefits directly to the health care provider providing such services, unless you advise us in writing prior to payment that you have already paid the charges and submitted paid receipts. 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 within the time frames described above. However, notices of adverse benefit determinations involving an urgent claim may be provided to you verbally within the time frames described above for expedited claim decisions. If verbal notice is given under such circumstances, then written notification will be provided to you no later than 3 days after the verbal notification.

A denial notice will state the specific reason or reasons for the adverse benefit determination, the specific Policy provisions on which the determination is based, and a description of the internal and external review procedures and associated timelines, including a statement of your right to bring a civil action under ERISA § 502(a), if applicable. The notice will include a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

The denial notice will also disclose any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse benefit determination. A copy of such internal rule, guideline, protocol, or other similar criterion will be provided to you, free of charge, upon request.

If the adverse benefit determination is based on the definition of medically necessary or experimental/investigational/unproven, the denial notice will include an explanation of the scientific or clinical judgment for the determination applying the terms of the Policy to your medical circumstances. Alternatively, the denial notice will include a statement that such explanation will be provided, free of charge, upon your request.

You also have the right to request, free of charge, the diagnosis code with its corresponding meaning and the treatment code with its corresponding meaning along with copies of all documents, records, and other information relevant to your claim for benefits.

**12. INTERNAL GRIEVANCE AND APPEALS PROCEDURES**

**A. General Grievance Information**

Situations might occasionally arise when you question or are unhappy with our claims decision or some aspect of service that you received from us. We can resolve most of your concerns without you having to file a grievance. Therefore, before filing a grievance, we urge you to speak with our Customer Service Department to try to resolve any problem, question, or concern that you have by calling 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 concern. If necessary, he/she will then discuss the matter with a supervisor in our Customer Service Department.
We will 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 the matter cannot be informally resolved, you have the right to file a grievance in writing with our Grievance/Appeal Committee in accordance with the procedure described below.

You also have the right to appeal an adverse benefit determination by filing a grievance. The grievance procedures described below are the only means through which an adverse benefit determination may be appealed.

B. Grievance Procedures

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.

Wisconsin Physicians Service Insurance Corporation
Attention: Grievance Coordinator
P. O. Box 7062
1717 West Broadway
Madison, Wisconsin 53707-7062
Fax Number: (608) 977-9920

Your grievance must be in writing as we cannot accept telephone requests for a grievance. Please deliver, fax, or mail your grievance to us at the address shown above. You have three years after you have received our initial notice of denial or partial denial of your claim to file a grievance.

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/investigative/unproven, please send us all additional medical information (including copies of your health care provider’s medical records) that shows why the health care service was medically necessary and/or not experimental/investigative/unproven under the Policy.

Any grievance filed by your health care practitioner regarding a prescription legend drug or 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, durable medical equipment or medical device that is not covered under the Policy.

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 do not receive this acknowledgement, please contact our Customer Service Department using the telephone number on your identification card.

As soon as reasonably possible after we receive your 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 will notify you by sending 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 (the “Committee”) for its review and decision in accordance with the grievance procedure explained further below.

You have the right to submit written questions/comments, documents, records, evidence, testimony, and other information relating to the claim for benefits that is the subject of your grievance to the Committee. The Committee will review your grievance and all relevant documents pertaining to the grievance without regard to whether such information was submitted or considered in the initial adverse benefit determination.

You also have a right to appear in person or to participate by teleconference before the Committee to present information to the Committee and to submit written questions to the Committee. The Committee will respond to any submitted written question in its notice to you of its final benefit determination. We 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 are followed. Also, cross-examination of the Committee’s members, its advisors, or WPS employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the Committee. However, your presentation to the Committee will be recorded. If you attend the meeting to present reason(s) for the grievance, we expect
and require each person who attends the meeting to follow and abide by our established internal practices, rules and requirements for handling grievances effectively and efficiently in accordance with applicable laws and regulations.

For decisions regarding medical judgment, the Committee will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will not be the same individual who was consulted regarding the initial adverse benefit determination or a subordinate of such individual. You have the right to request, free of charge, the identity of the health care professional whose advice we obtained in connection with the adverse benefit determination, regardless of whether such advice was relied upon in making a decision.

In addition, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your grievance. Furthermore, as part of providing an opportunity for a full and fair review, we will provide you with any new or additional evidence considered, relied upon, or generated by us in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a final adverse benefit determination is required to be provided to you for purposes of providing you a reasonable opportunity to respond prior to that date.

Before a final adverse benefit determination is made based on a new or additional rationale, we will provide you, free of charge, with the rationale. Such rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to you for purposes of providing you with a reasonable opportunity to respond prior to that date.

In the event the new or additional evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the deadline for providing a notice of final adverse benefit determination is tolled until such time is reasonable for providing you an opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, we will notify you of our final decision as soon as we reasonably can, taking into account any medical exigencies.

For a grievance that is not also an adverse benefit determination, we will mail you a letter explaining our decision within 30 days. However, this period may be extended one time by an additional 30 days if we determine that an extension is necessary. We will notify you of the extension prior to the end of the initial 30-day period, the circumstances requiring the extension, and the date by which we expect to make a decision.

For a grievance that is also an adverse benefit determination, we will notify you of our final decision as soon as possible, but not later than as follows:

1. **Pre-Service Claims.** We will notify you of our final decision as soon as possible, but not later than 30 day after our receipt of your grievance for a pre-service claim.

2. **Post-Service Claims.** We will notify you of our final decision as soon as possible, but not later than 60 days after our receipt of your grievance for a post-service claim.

3. **Concurrent Care.** We will notify you of our final decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. We shall decide the appeal of a denied request to extend any concurrent care decision in the appeal time frame for a pre-service claim, urgent claim, or a post-service claim, as appropriate to the request.

4. **Expedited Grievances.** We will notify you of our final decision as soon as possible, but not later than 72 hours after receipt of the expedited grievance. An expedited grievance includes an appeal of an urgent claim.

C. **Expedited Grievance Procedure**

To file an expedited grievance, you or your health care practitioner must submit the concerns, issues, and comments underlying your grievance to us verbally via telephone or in writing via 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 mail, email, or fax:
Wisconsin Physicians Service Insurance Corporation  
Attention: Grievance Coordinator-Expedited Grievance  
P. O. Box 7062  
1717 West Broadway  
Madison, Wisconsin 53707-7062  
Phone: 1-800-332-6451 (toll-free)  
Fax Number: (608) 977-9920

For example, if we denied benefits because we determined that a health care service provided to you was not medically necessary and/or experimental/investigative/unproven, please send us all additional medical information, including sending us copies of your health care provider’s medical records, that you believe shows that the health care service is medically necessary and/or not experimental/investigative/unproven under the Policy.

Any expedited grievance filed by your health care practitioner 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, durable medical equipment or medical device that is not covered under the Policy.

As soon as reasonably possible following our receipt of the expedited grievance, our Grievance/Appeal Department will review the expedited grievance. If we agree with the proposed resolution of this matter, we will 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 expedited grievance. If our Grievance/Appeal Department upholds our original claims processing decision or administrative decision that you disputed, the expedited grievance will be automatically forwarded to our Grievance/Appeal Committee (the “Committee”) for its review and decision in accordance with the procedure explained below. Under no circumstances will the time frame exceed the time period discussed below.

You have the right to submit written questions/comments, documents, records, evidence, testimony, and other information relating to the claim for benefits that is the subject of your expedited grievance. The Committee will review your expedited grievance and all relevant documents pertaining to it without regard to whether such information was submitted or considered in the initial adverse benefit determination.

You also have a right to appear in person or to participate by teleconference before the Committee to present information to the Committee and to submit written questions to the Committee. The Committee will respond to any submitted written question in its notice to you of its final benefit determination. We will notify you of the time and place of the meeting as soon as reasonably possible. Please remember that this meeting is not a trial where there are rules of evidence are followed. Also, cross-examination of the Committee’s members, its advisors, or WPS employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the Committee. However, your presentation to the Committee will be recorded. If you attend the meeting to present reason(s) for the expedited grievance, we expect and require each person who attends the meeting to follow and abide by our established internal practices, rules and requirements for handling expedited grievances effectively and efficiently in accordance with applicable laws and regulations.

For decisions regarding medical judgment, the Committee will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will not be the same individual who was consulted regarding the initial adverse benefit determination or a subordinate of such individual. You have the right to request, free of charge, the identity of the health care professional whose advice we obtained in connection with the adverse benefit determination, regardless of whether such advice was relied upon in making a decision.

In addition, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your expedited grievance. Furthermore, as part of providing an opportunity for a full and fair review, we will provide you with any new or additional evidence considered, relied upon, or generated by us in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a final adverse benefit determination is required to be provided to you for purposes of providing you a reasonable opportunity to respond prior to that date.

Before a final adverse benefit determination is made based on a new or additional rationale, we will provide you, free of charge, with the rationale. Such rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to you for purposes of providing you with a reasonable opportunity to respond prior to that date.
In the event the new or additional evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the deadline for providing a notice of final adverse benefit determination is tolled until such time is reasonable for providing you an opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, we will notify you of our final decision as soon as we reasonably can, taking into account all medical exigencies.

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 Committee’s rationale and decision. Not later than 3 days following, 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.

A notice of a final adverse benefit determination will state the specific reason or reasons for the final adverse benefit determination, the specific Policy provisions on which the determination is based, and a description of the external review procedures and associated timelines, including a statement of your right to bring a civil action under ERISA § 502(a), if applicable. The notice will include a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

The denial notice will also disclose any internal rule, guideline, protocol or other similar criterion that was relied upon in making the final adverse benefit determination. A copy of such internal rule, guideline, protocol, or other similar criterion will be provided to you, free of charge, upon request.

If the final adverse benefit determination is based on the definition of medically necessary or experimental/investigational/unproven, then the denial notice will provide you with either an explanation of the scientific or clinical judgment for the determination applying the terms of the Policy to your medical circumstances or a statement that such explanation will be provided, free of charge, upon your request.

You also have the right to request, free of charge, the diagnosis code with its corresponding meaning and the treatment code with its corresponding meaning along with copies of all documents, records, and other information relevant to your claim for benefits.

We will retain our records of the expedited grievance for at least six years after we send you notice of our final decision.

You have the right to request, free of charge, copies of all documents, records, and other information relevant to your expedited grievance by sending a written request to the address listed above.

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.

D. Final Claim Decisions

A notice of a final adverse benefit determination will state the specific reason or reasons for the final adverse benefit determination, the specific Policy provisions on which the determination is based, and a description of the external review procedures and associated timelines, including a statement of your right to bring a civil action under ERISA § 502(a), if applicable. The notice will include a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

The denial notice will also disclose any internal rule, guideline, protocol or other similar criterion that was relied upon in making the final adverse benefit determination. A copy of such internal rule, guideline, protocol, or other similar criterion will be provided to you, free of charge, upon request.

If the final adverse benefit determination is based on the definition of medically necessary or experimental/investigational/unproven, then the denial notice will provide you with either an explanation of the scientific or clinical judgment for the determination applying the terms of the Policy to your medical circumstances or a statement that such explanation will be provided, free of charge, upon your request.

You also have the right to request, free of charge, the diagnosis code with its corresponding meaning and the treatment code with its corresponding meaning along with copies of all documents, records, and other information relevant to your claim for benefits.
We will retain our records of the grievance or expedited grievance for at least six years after we send you notice of our final decision.

You have the right to request, free of charge, copies of all documents, records, and other information relevant to your grievance or expedited grievance by sending a written request to the address listed above.

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.

13. INDEPENDENT EXTERNAL REVIEW

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 described above 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.

Wisconsin Physicians Service Insurance Corporation
Attention: IRO Coordinator
P.O. Box 7458
Madison, WI 53707

Your request for an independent external review must include:

1. Your name, address and telephone number;
2. An explanation of why you believe that the treatment should be covered;
3. Any additional information or documentation that supports your position;
4. If someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative; and
5. Any other information we request.

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 WPS 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.

The IRO’s medical director or other medical professional will review your request and decide if an immediate review is needed. If so, it will review your dispute on an expedited basis and make a decision within 72 hours. If the IRO decides that your illness or injury does not require its immediate review of your dispute, it will notify you that you must first complete our internal grievance and appeals process.

Unless your case involves the rescission of the Policy, the IRO’s decision is binding for both you and WPS. You are not responsible for costs associated with the independent external review.
14. DEFINITIONS

In this Certificate, all italicized terms have the meanings set forth below, regardless of whether they appear as singular or plural.

**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.

**Adverse Benefit Determination:** any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a **benefit**, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a **benefit** resulting from the application of any utilization management, as well as a failure to cover an item or service for which **benefits** are otherwise provided because it is determined to be experimental/investigational/unproven or not medically necessary or appropriate.

An **adverse benefit determination** includes any rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, regardless of whether or not, in connection with the rescission, there is an adverse effect on any particular **benefit** at that time.

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

1. We have reviewed admission to a health care facility, the availability of care, the continued stay or other treatment;
2. Based on the information provided, the treatment does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; and
3. 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.

**Ambulance Services:** ground and air transportation: (1) 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 (2) which is staffed by emergency medical technicians, paramedics, or other certified medical professionals.

**Authorized Representative:** a person designated to file a claim for **benefits** or a grievance on your behalf and/or to act for you in pursuing a claim for **benefits** under the Policy.

**Behavioral Health Services:** health care services for the treatment of substance use disorders and nervous or mental disorders.

**Benefit:** 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.

**Biosimilar(s):** a prescription legend drug of biological origin developed such that there are no clinically meaningful differences between the biological product and its FDA-approved reference product in terms of safety, purity, and potency,
and demonstrates similarity to the reference product in terms of quality characteristics, biological activity, safety and efficacy. A biosimilar may be classified as a brand-name drug, generic drug, and/or specialty drug.

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

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 the equivalent generic drug. The term brand-name drug may also include over-the-counter drugs that we determine to be covered drugs.

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 will start on January 1st of that year and end on December 31st of that same year.

Category B Devices: as determined by the FDA, nonexperimental/investigational devices where the incremental risk is the primary risk in question (i.e., underlying questions of safety and effectiveness of that device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained FDA approval for that device type.

In order to be covered as a category B device, the device must meet all of the following criteria:

1. Used within the context of an FDA-approved clinical trial;
2. Used according to the clinical trial's approved protocols;
3. Fall under a covered benefit category and not excluded by law, regulation or current Medicare coverage guidelines;
4. Medically necessary for the covered person, and the amount, duration and frequency of use or application of the service is medically appropriate; and
5. Furnished in a setting appropriate to the covered person’s medical needs and condition.

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 biological child of a subscriber.
3. A legally adopted child or a child placed for adoption with the subscriber.
4. A child solely under the subscriber’s (or his/her spouse’s) court-ordered legal guardianship as determined by us.
5. A child who is considered an alternate recipient under a qualified medical child support order. See Section 2. F. 6. (Eligibility, Enrollment, and Effective Date / Special Enrollment Periods / Child Support Order) for additional information about child support orders.
6. The child of a subscriber’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: an implantable instrument or device that is designed to enhance hearing.

Coinsurance: your share of the costs of a covered health care service, calculated as a percent of the charge for a covered expense.
Collateral: a member of your immediate family.

Concurrent Care Decision: a decision by us to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by us or a decision with respect to a request by you to extend a course of treatment beyond the period of time or number of treatments that has been approved by us.

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 health care practitioners acting within the scope of their respective licenses.

Copayment: a specific dollar amount that you are required to pay to the health care provider towards the charge for certain covered expenses. 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 charge for the covered expense.

Correctly Filed Claim: a claim that includes: (1) the completed claim forms that we require; (2) the actual itemized bill for each health care service; and (3) 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.

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

Covered Dependent: an eligible dependent 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 subscriber and/or his/her covered dependent(s).

Covered Transplant Drugs: immunosuppressant drugs prescribed by a physician when dispensed by a health care 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.

Custodial Care: services that are any of the following:

1. Non-health-related services, such as assistance in activities of daily living.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function unless eligible for habilitative services benefits (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. 24-hour supervision for potentially unsafe behavior.
4. Supervision of medication which usually can be self-administered.
5. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Services may still be considered custodial care by us even if:

1. You are under the care of a health care practitioner;
2. The health care practitioner prescribes health care services to support and maintain your physical and/or mental condition;
3. Services are being provided by a nurse; or
4. Such care involves the use of technical medical skills if such skills can be easily taught to a layperson.
Day Treatment Program: nonresidential program for the treatment of substance use disorders and nervous or mental disorders that is 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.

Deductible: the specified amount you are required to pay for covered expenses in a calendar year before benefits are payable under the Policy. This defined term does not include a specialty drug deductible.

Delegate: a vendor we contract with to perform services on our behalf. This includes any vendors the contracted vendor uses in providing services to us.

Designated Transplant Facility: a facility that is (i) approved by us to be the most appropriate facility for your approved transplant services; (ii) contracted to provide approved transplant services to covered persons pursuant to an agreement with one of our transplant provider networks, (iii) a preferred provider when transplant services are provided while you are not confined in a hospital; or (iv) any other health care provider approved by us. Designated transplant facilities are shown in the Schedule of Benefits as preferred providers.

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).

Domestic Partner: (This definition only applies if shown in the policyholder's current application for coverage as being applicable.) a person who occupies the same dwelling unit with a subscriber if all of the following conditions are met:

1. The person is in a committed relationship (relationship of mutual support, caring and commitment and intend to remain in such a relationship in the immediate future) with the subscriber;
2. Each partner is 18 years of age or older;
3. 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;
4. Each partner is competent to contract;
5. 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;
6. There are no blood ties between the subscriber and his/her partner closer than that permitted for marriage or for domestic partner registration;
7. The relationship of the subscriber and his/her partner is not merely temporary, social, political, commercial or economic in nature (i.e., there must be mutual financial interdependency); and
8. The subscriber has registered his/her partner as a domestic partner with the policyholder and WPS by providing proof that, for at least the six month period immediately preceding the date of registration, the subscriber either 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 has any three of the following with respect to the 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 partner as a beneficiary of the subscriber's will;
e. Designation of the partner as a beneficiary for the subscriber’s life insurance or retirement benefits;

f. Designation of the partner as holding power of attorney for health care; or

g. Shared household expenses.

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

1. A subscriber’s legal spouse.

2. A subscriber’s child, under the age of 26.

3. A full-time student returning from military duty.

4. A subscriber’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 subscriber for support and maintenance;
   d. The child’s incapacity existed before he/she reached age 26; and
   e. The subscriber’s family coverage remains in force under the Policy.

5. A biological child of a subscriber’s child if the subscriber’s child is under 18 years old.

6. If shown in the policyholder’s current application for coverage as being applicable, a subscriber’s domestic partner.

7. A child, under the age of 26, for whom the subscriber was the legal guardian prior to the child turning 18 years of age.

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 application for coverage; or (2) identified by the policyholder as a person 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 health care practitioner that: (1) occurs at the emergency room; and (2) includes only the charges for the emergency room fee billed by the facility for use of the emergency room.

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

1. The duration of the standard resolution process will result in serious jeopardy to your life or health or your ability to regain maximum function.

2. A health care practitioner 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.

3. A health care practitioner with knowledge of your medical condition determines that the grievance will be treated as an expedited grievance.
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 (FDA) upon completion of Phase III clinical investigation;
4. It is being used in a way that is not approved by the 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; or
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 practitioner has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

We have full discretionary authority to determine whether a health care service is experimental/investigational/unproven. In any dispute arising as a result of our determination, such determination will be upheld if it is based on any credible evidence. If our decision is reversed, your only remedy will be our provision of benefits in accordance with the Policy. You will not be entitled to receive any compensatory damages, punitive damages, or attorney's fees, or any other costs in connection therewith or as a consequence thereof.

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

1. We have reviewed the proposed treatment;
2. Based on the information provided, we have determined the treatment is experimental/investigational/unproven; and
3. Based on the information provided, we denied the treatment or payment for the treatment.

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

Formulary: a list of drugs that are covered under the pharmacy benefit, which is available at http://www.wpshealth.com/resources/files/32772-2019-wps-ind-small-group-drug-formulary.pdf. The formulary contains generic drugs, brand-name drugs, specialty drugs and biosimilars which may be classified as either specialty drugs, preferred drugs or non-preferred drugs.

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:** a child of a subscriber who meets all of 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;

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.

Additionally, the 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; (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 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 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 to use transportation, shop, or handle finances.

**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 the brand-name drug equivalent. The term generic drug may also include over-the-counter drugs that we determine to be covered drugs.

**Genetic Testing:** testing that involves analysis of human chromosomes, DNA, RNA, genes and/or gene products (e.g., enzymes, other types of proteins, and selected metabolites) which is predominantly used to detect potential heritable disorders, screen for or diagnose genetic conditions, identify future health risks, predict drug responses (pharmacogenetics), and assess risks to future children. Genetic testing may also be applied to gene mutations that occur in cells during a person’s lifetime.

Genetic testing includes, but is not limited to: (1) gene expression and determination of gene function (genomics); (2) analysis of genetic variations; (3) multiple gene panels; (4) genetic biomarkers; (5) biochemical biomarkers; (6) molecular pathology; (7) measurements of gene expression and transcription products; (8) cyto genetic tests; (9) topographic genotyping; (10) microarray testing; (11) whole genome sequencing; and (12) computerized predictions based on the results of the genetic analysis.

**Geographical Service Area:** the region in which WPS operates and your Policy is available, as determined by us. Please see wpshealth.com for more information.

**Grievance:** any dissatisfaction with us or our administration of your health benefit plan that you 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.

**Habilitative Services:** health care services that help a person keep, learn, or improve skills and functioning for activities of 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 Practitioner:** one of the following licensed practitioners who perform services payable under this Policy: a Doctor of Medicine (MD), a Doctor of Osteopathy (DO), a Doctor of Podiatric Medicine (DPM); a Doctor of Dental Surgery (DDS), a Doctor of Dental Medicine (DMD); a Doctor of Chiropractic (DC); a Doctor of Optometry (OD); a physician assistant (PA); a nurse practitioner (NP); a certified nurse midwife (CNM); a psychologist (Ph.D., Psy.D.), a licensed mental health professional, including but not limited to clinical social worker, marriage and family therapist or professional counselor; a physical therapist; an occupational therapist; a speech-language pathologist; an audiologist; or any
other licensed practitioner that is acting within the scope of their license and performing a service that would be payable under the Policy.

**Health Care Provider**: any physician, health care practitioner, 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, hospital services, surgical services, maternity services, medical services, procedures, drugs, medicines, devices, supplies, or any other service directly provided to you by a health care provider.

**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**: including, but not limited to: 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 health care practitioner; (2) the plan is approved by your attending health care practitioner in writing; (3) the plan is reviewed by your attending health care practitioner every two months (or less frequently if your health care practitioner 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 Delivery Pharmacy**: a preferred pharmacy that dispenses extended supplies of maintenance medications (typically greater than a 30-34 day supply).

**Home Health Aide Services**: services performed by a home health aide which: (1) are not required to be performed by a registered nurse or licensed practical nurse; and (2) primarily aid the patient in performing normal activities of daily living, which may include custodial care.

**Hospice Care**: health care services that are: (a) provided to a covered person whose life expectancy, as certified by a health care practitioner, is six consecutive months or less; (b) available on an intermittent basis with on-call health care services available on a 24-hour basis; and (c) 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 facilities for the diagnosis and treatment of illness or injury. A professional staff of licensed health care practitioners 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 illnesses or injuries. 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) sub-acute care center; or (7) a health resort, spa or sanitarium.

**Illness**: a physical illness, a substance use disorder, 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 aids.

**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.

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

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 practitioner.

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; and
5. Direct attempts to cause or maintain pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; GIFT or ZIFT; embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury: bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes.

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.

Limited Family Coverage: coverage that applies to: (1) a subscriber and his/her eligible spouse or domestic partner who is a covered dependent; or (2) a subscriber and his/her 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 preferred provider, the maximum allowable fee is the rate negotiated between us and the preferred provider. For a covered health care service provided by a non-preferred provider, the maximum allowable fee is the maximum out-of-network allowable fee.

If you submit a written or oral request for our maximum allowable fee for a health care service and 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 the specific health care service you identified. This 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-preferred 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 involving acute and abnormal symptoms of such severity (including severe pain) that a prudent and 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 a 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 a person's bodily functions; or
3. Serious dysfunction of one or more of a person's body organs or parts.

**Medically Necessary:** a health care service 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 of care for the condition being evaluated or treated;
3. Substantiated by the clinical documentation;
4. The most appropriate and cost effective 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 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 health care practitioner 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; (4) not primarily for the patient’s comfort or convenience; and (5) prescribed by a health care practitioner.

**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, autism or developmental delays are not nervous or mental disorders.

**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 preferred providers. Non-designated transplant facilities are shown in the Schedule of Benefits as non-preferred providers.
Non-Preferred Provider: a health care provider that has not entered into a written agreement with the health care network selected by the policyholder or covered person as of the date upon which the services are provided.

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.

Observation Care: Clinically appropriate outpatient hospital services, which include ongoing short term treatment, assessment, and reassessment prior to your health care practitioner determining if you will require further treatment as a hospital inpatient or if they can discharge you from the hospital.

Office Visit: either of the following:

1. For health care services other than behavioral health services, a meeting between you and a health care practitioner that: (a) occurs at the health care practitioner’s office, a medical clinic, convenient care clinic, ambulatory surgical center, a free-standing urgent care center, skilled nursing facility, the outpatient department of a hospital other than an emergency room, or in your home; 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 health care practitioner, other than services related to physical therapy.

2. For behavioral health services, a meeting between you and a health care practitioner licensed to provide nonresidential services for the treatment of nervous or mental disorders and/or substance use disorders that: (a) occurs in the health care practitioner’s office, a medical clinic, a free-standing urgent care center, skilled nursing facility, outpatient treatment facility, the outpatient department of a hospital, other than an emergency room or in your home; 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.

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.

Out-of-Pocket Limit: the maximum amount that you are required to pay each calendar year for covered expenses. This limit is shown in the Schedule of Benefits. Any of the following costs will count towards your out-of-pocket limit: (1) deductible; (2) copayments; and (3) coinsurance amounts you pay for covered expenses associated with health care services. 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 the maximum allowable fee.

Palliative Care: care that optimizes quality of life for people with serious illness by anticipating, preventing, and treating their suffering. Palliative care may be provided throughout the continuum of illness. It generally involves addressing physical, emotional, and social needs and facilitating patient autonomy, access to information, and choice.

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 substance use disorders or nervous or mental disorders.

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 Podiatric Medicine (D.P.M.); Doctor of Optometry (O.D.); or Doctor of Chiropractic (D.C.);

2. Is a medical doctor or surgeon holding a license or certificate of registration from the medical examining board in the state in which he/she is located; and

3. Practices medicine within the lawful scope of his/her license.
Placed for Adoption / Placement 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 subscriber’s home for adoption and enters into an agreement under § 48.63(3)(b)4. or § 48.833(1) or (2) with the subscriber;

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 subscriber’s home for adoption;

3. A sending agency, as defined in Wis. Stat. § 48.988(2)(d), places a child in a subscriber’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 as a preliminary step to a possible adoption, and the subscriber 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 subscriber takes physical custody of the child at any location within the United States; or

5. A court of a foreign jurisdiction appoints a subscriber as guardian of a child who is a citizen of that jurisdiction, and the child arrives in the subscriber’s home for the purpose of adoption by the subscriber under Wis. Stat. § 48.839.

Policyholder: the employer or other organization that purchased the Group Master Policy pursuant to which this Certificate was issued.

Post-Service Claim: any claim for a benefit under the Policy that is not a pre-service claim.

Preferred Drug(s): any generic drug or brand-name drug named on our list of preferred drugs, which is available at https://wpshealth.com/resources/files/32772-wps-ind-small-group-drug-formulary.pdf. The drugs designated as preferred drugs on our formulary may change from time to time.

Preferred Pharmacy: a pharmacy that we have contracted with and that bills us directly for the charges you incur for covered drugs.

Preferred Provider: a health care provider that has entered into a written agreement with the network shown on your WPS identification card as of the date upon which the services are provided. Please refer to our on-line directory or contact us for a listing of preferred providers. A health care provider’s preferred status may change from time to time so you should check it frequently. You may be required to pay a larger portion of the cost of a covered health care service if you see a non-preferred provider.

Prescription Legend Drug: any medicine whose label is required to contain the following or similar wording: “Caution: Federal Law prohibits dispensing without prescription.” Prescription legend drug also includes investigational drugs used to treat the HIV virus as described in Wis. Stat. § 632.895(9), 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 health care practitioner with the authority to prescribe a drug for you.

Pre-Service Claim any claim for a benefit with respect to which the terms of the Policy condition receipt of a benefit, in whole or in part, on receiving prior authorization before obtaining medical care.

Preventive Care Services: health care services that are not for the diagnosis or treatment of an illness or injury and 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.

Preventive Drug(s): drugs that we are currently required by law to define as preventive drugs include: (1) aspirin for the prevention of cardiovascular disease (age 50-59) and after 12 weeks of gestation in women who are at high risk for preeclampsia; (2) fluoride supplements if you are older than six months but younger than 17 years old; (3) folic acid for women planning or capable of pregnancy; (4) oral contraceptives, contraceptive patches, contraceptive devices (e.g., diaphragms, sponges, gel) and contraceptive vaginal rings for birth control; (5) nicotine replacements (e.g., patches and gum) and covered drugs used for smoking cessation if you are age 18 and over; (6) 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; (7) immunizations; (8) low/moderate dose statins for ages 40-75 with at least one cardiovascular disease risk factor and a 10-year calculated risk of at least 10%; and (9) bowel preparations related to a preventive colonoscopy. The USPSTF may change the definition of preventive drugs during the course of the year. Please see https://www.uspreventiveservicestaskforce.org/Page/Name/uspsf-a-and-b-recommendations/.

Primary Care Practitioner: a provider who is a health care practitioner who directly provides or coordinates a range of health care services for a patient. A primary care practitioner’s primary practice must be Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology or Pediatrics.

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.

Qualifying Clinical Trial: with respect to cancer or other life-threatening conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening condition and which meets any of the criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening conditions, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of a disease or disorder that is not a life-threatening condition and that meets any of the criteria in the bulleted list below.

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   a. National Institutes of Health (NIH), including the National Cancer Institute (NCI).
   b. Centers for Disease Control and Prevention (CDC).
   c. Agency for Healthcare Research and Quality (AHRQ).
   d. Centers for Medicare and Medicaid Services (CMS).
   e. A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
      1) Comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
      2) Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

2. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In order to be a qualifying clinical trial, the clinical trial must also have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial. Additionally, the subject or purpose of the trial must be the evaluation of an item or service would be covered under the Policy if it were not experimental/investigational/unproven.
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.

Rehabilitative Services: health care services that help a person keep, get back or improve skills and functioning for activities of daily living that have been lost or impaired because a person had an illness, injury, or was 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.

Rescission of Coverage Determination: a determination by Arise 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.

Respite Care: services provided to give a primary caregiver temporary relief from caring for an ill individual.

Routine Patient Care Costs:

1. Include 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; and
   d. Covered health care services needed for reasonable and necessary care arising from the provision of a trial health care service.

2. Do not include costs associated with any of the following:
   a. Experimental/investigational/unproven health care services with the exception of:
      1) 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.

Single Coverage: coverage that applies only to a subscriber.

Skilled Nursing Care: health care services that: (1) are furnished pursuant to a health care practitioner's orders; (2) require the skills of professional personnel such as a registered nurse or a licensed practical nurse; and (3) are provided either directly by or under the direct supervision of such professional personnel. Patients receiving skilled nursing care are usually quite ill and often have been recently confined in a hospital. In the majority of cases, skilled nursing care is only necessary for a limited time period. After that, most patients have recuperated enough to be cared for by “nonskilled” persons such as spouses, children, or other family or relatives. The following examples are generally considered care that can be provided by “nonskilled” persons, and therefore do not qualify as skilled nursing care: range of motion exercises, strengthening exercises, simple wound care, ostomy care, tube and gastrostomy feedings, administration of basic medications, maintenance of urinary catheters, assistance with performing activities of daily living, and supervision for potentially unsafe behavior.
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 health care practitioner 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 care or maintenance care;
5. Requires compensation from its patients;
6. Admits patients only upon a health care practitioner’s orders;
7. Has an agreement to have a health care practitioner’s services available when needed;
8. Maintains adequate records for all patients; and
9. Has a written transfer agreement with at least one hospital.

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 wpshealth.com or call the telephone number shown on your identification card.

Specialty Drug Deductible: the specified amount you are required to pay for covered specialty drugs in a calendar year before benefits are payable under the Policy.

Specialty Health Care Practitioner: a preferred provider who is a health care practitioner whose primary practice is other than one of the following: Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology and Pediatrics.

Specialty Pharmacy: a preferred pharmacy designated by us to dispense specialty drugs. To locate a specialty pharmacy, contact us by calling the telephone number shown on your identification card or visit the website of the pharmacy benefit manager listed on your identification card.

Subscriber: an eligible employee who has properly enrolled and been approved by us for coverage under the Policy.

Substance Use Disorder: a disorder that is listed in the current “Diagnostic and Statistical Manual of the American Psychiatric Association” (DSM-5). According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

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 health care practitioner that we recognize as treatment of an illness or injury; or (2) those services we identify as surgical services, including male sterilization procedures and preoperative and postoperative care.

Telemedicine: the delivery of clinical health care services via telecommunications technologies, including but not limited to telephone and interactive audio and video conferencing.

Therapy Visit: a meeting between you and a health care practitioner, excluding a massage therapist that: (1) occurs in the health care practitioner’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, or occupational therapy.
Totally Disabled or Total Disability: being unable due to illness or injury to perform the essential functions of any job or, for eligible 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 health care practitioner. We have the right to examine any covered person who claims 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.

Transitional Treatment: services for the treatment of nervous or mental disorders and substance use disorders 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 treatment includes any of the following health care services if provided by a health care provider certified by the Department of Health Services:

1) Mental health services for covered adults in a day treatment program;
2) Mental health services for covered children and adolescents in a day treatment program;
3) Services for covered persons with chronic nervous or mental disorders provided through a community support program;
4) Residential treatment programs for the therapeutic treatment of a covered person's nervous or mental disorders and/or substance use disorders, including therapeutic communities and transitional facilities;
5) Services for substance use disorders provided in a day treatment program;
6) Intensive outpatient programs for substance use disorders and for treatment of nervous or mental disorders; and
7) 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.

Transitional treatment also includes out-of-state services and programs that are substantially similar to 1. through 7. above if the health care provider is in compliance with similar requirements of the state in which the health care provider is located.

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, health care practitioner's charges, organ and tissue acquisition, tissue typing, and ancillary services.

Treatment: management and care directly provided to you by a health care practitioner 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.

Urgent Claim: any pre-service claim for medical care or treatment with respect to which the application of the time periods for making decisions described in Section 11. C. 3. (Claim Filing and Processing Procedures / Claim Processing Procedure / Pre-Service Claims):

1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2. In the opinion of a health care practitioner 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.

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.
15. WISCONSIN DEPARTMENT OF INSURANCE CONTACT INFORMATION


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 file a complaint electronically with the OFFICE OF THE COMMISSIONER OF INSURANCE at its website at http://oci.wi.gov/, or by writing to:

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

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