Certificate of Coverage - PPO

Wisconsin Physicians Service Insurance Corporation
1717 West Broadway, P.O. Box 8190
Madison, WI 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 *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 Physician, 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.

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

Marcus Julian
Chief Health Plan 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 eligible employees and their eligible 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 types available under the Group Master Policy and as outlined in the Schedule of Benefits. One benefit type, *preferred provider*, applies when you receive covered *health care services* from a *preferred provider*. The other benefit type, *non-preferred provider*, 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 a 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 as outlined in the Schedule of Benefits. 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.*

Coverage of all services is subject to medical necessity and services deemed *experimental/investigational/unproven* under the terms of the clinical guidelines will not be covered.

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.*
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 giving 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 himself/herself and his/her 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 E. (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 unless a different date is shown in the *policyholder's* current application for coverage. 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* and/or *eligible dependent* will be able to enroll in the Policy outside the annual enrollment period. These circumstances are explained below.

Except as noted below, the *policyholder* 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 the *policyholder* timely receives an application, coverage for the *eligible employee* and/or his/her *eligible dependents* will begin, as determined by us, on (1) the date the *eligible employee* experiences the special late enrollment circumstance due to marriage, birth, adoption or *placement for adoption* of a *child*, child support order, or by court order; or (2) the first day following the date the *eligible employee's* other health coverage ended for loss of coverage; or (3) the first day of the calendar month following our receipt of the completed application and affidavit for a *domestic partner*; or (4) the first day of the calendar month following our receipt of the completed application when eligible for a premium assistance subsidy under Medicaid. If the *policyholder* does not receive the application within the stated 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 thirty-one (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.

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*.

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 (1) 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 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 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 himself/herself and any *eligible dependents*. If we receive an application **within 31 days** after the date of marriage, the *eligible employee* and any *eligible dependents*' coverage will be effective on the date of marriage. 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.

4. Birth of a Child

a. **If a *subscriber* has *family coverage*,** coverage is provided for a newborn biological *child* who meets the definition of *eligible dependent* from the moment of that *child's* birth. You should notify the *policyholder* of the *child's* birth.

b. **If a *subscriber* has *single coverage*,** 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.

To add a newborn biological *child*, you must submit an application to the *policyholder* and pay any required premium within 60 days after the date of birth. If you fail to notify the *policyholder* 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 the *policyholder* does 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* wants 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*; whichever occurs first.

If the *policyholder* receives the application after the 60-day enrollment period ends, the *child* may not be added until the next annual open 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. Court Order

If a *subscriber* wants to obtain coverage for a *child* because of a court order (e.g., permanent guardianship), the *policyholder* must receive an application listing the *child* within 31 days after the date of the court order, a copy of the court order and any required premium. The effective date for coverage will be the later of the following: (a) the date of the court order (b) the date specified within the court order; or (c) a later date elected by the *subscriber;* provided that *child* is an *eligible dependent* for coverage under this Policy, as determined by us. If the *policyholder* receives the application after the 31-day enrollment period ends, the *child* may not be added until the next annual enrollment period.

It is the *subscriber's* responsibility to notify us if court order changes and 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.

8. Adding a Domestic Partner

This paragraph 8. 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. Preferred Provider Benefits

1. Unless otherwise stated in the Policy, the *preferred provider* benefits shown in your Schedule of Benefits are payable when *health care services* are received from any of the following:

a. A *preferred provider*.

b. A non-*preferred provider* if you are receiving covered *emergency medical care*.

c. A radiologist, pathologist, or anesthesiologist when ordered by a *preferred provider*.

d. A *non-preferred provider* if you are receiving air ambulance services.

e. A *non-preferred provider* if you are receiving *health care services* at a *preferred facility* unless you sign a No Surprises Act notice and consent form.

Charges for *covered expenses* received from a *non-preferred provider* are limited to the amounts which are determined as being the *maximum allowable fee*.

2. *Preferred providers* are not permitted to bill you for any *medically necessary covered expenses* above the *maximum allowable fee*. *Health care services* you receive from *preferred providers* are only subject to your *cost sharing*. See section 4. (Payment of Benefits) for additional information about the costs you are responsible for under the Policy.

3. *Non-preferred providers* may bill you for the difference between the amount billed and the amount that we determine to be the *maximum out-of-network allowable fee*, as shown in paragraph B., below, even if the services are applied to your *participating provider benefits* under paragraph 1., above, except as stated in paragraph 4. below.

4. *Non-preferred providers* providing:

a. E*mergency medical care* in an emergency department of a *hospital* or in an *independent freestanding emergency department.*

b. Air ambulance services.

c. *Health care services* at a *preferred facility*, as required by state or federal law, are not permitted to bill you for any covered expenses above the *qualifying payment amount*. Exception: if a *covered person* signs the provider's No Surprises Act notice and consent form, *health care services* provided under c. will be covered subject to paragraph B. below. Such *health care services* are only subject to your *preferred provider cost sharing* amount. See section 4. (Payment of Benefits) for additional information about the costs you are responsible for under the Policy.

B. Non-Preferred Provider Benefits

1. If you receive *health care services* from a *non-preferred provider, benefits* are limited to the *maximum out-of-network allowable fee,* and you will be responsible for paying any difference between that amount and the *charge* billed. For example, if the *non-preferred provider's charge* is $1,000 and the *maximum out-of-network allowable fee* is $700, you will be responsible for paying the remaining balance of $300 in addition to any applicable *cost sharing* amounts.

2. If you receive the following services, you will not incur any greater out-of-pocket costs if the covered service had been provided by a *preferred provider*:

a. E*mergency medical care* in an emergency department of a *hospital* or in an *independent freestanding emergency department.*

b. Air ambulance services.

c. *Health care services* at a *preferred facility,* from a *non-preferred provider*, as required by state or federal law, *benefits* are limited to the *qualifying payment amount.*

3. If you sign the *non-preferred provider's* No Surprises Act notice and consent form, *benefits* will be subject to paragraph 1. above for the *health care services* described in the form. Exception: the notice and consent form will not apply to the following ancillary services provided by a *non-preferred provider* at a *preferred facility*:

a. *Health care services* related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.

b. *Health care services* provided by assistant surgeons, hospitalists, and intensivists.

c. Diagnostic services, including radiology and laboratory services.

d. *Health care services* provided by a *non-preferred provider* when a *preferred provider* is unavailable at the *preferred facility*.

C. 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 *medically necessary*, cost effective, and aligned with clinical standards. *Prior authorization* does not guarantee payment or verify eligibility. Payment of *benefits* are subject to all terms, conditions, limitations, and exclusions of your Policy at the time of service. This process helps 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 must 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 https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf. Please refer to this website often, as we have full discretionary authority and may change it from time to time without giving 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: https://www.wpshealth.com/resources/provider-resources/prior-authorization.shtml. 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 https://www.wpshealth.com/resources/files/drugpreauth.pdf. 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. JJ. (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 the documentation provided and send a written response to you and/or the *health care provider* who submitted the request within the time frame required by law. See sections 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.

   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 *PCP*) to obtain *emergency medical care* or *urgent care* at an emergency or urgent care facility.

D. Coding Errors

In some cases, we may 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).

E. 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.

F. Case Management

WPS case management services are available without additional cost to you. Case managers can help you:

1. Navigate the health care system.

2. Identify and monitor your health care needs.

3. Implement care plans to keep you healthy or manage your *illnesses*.

4. Learn how to prevent falls.

5. Eliminate barriers to receiving care.

6. Learn more about your condition, benefits, and medications.

7. Find resources in your community.

8. Learn about hospice and *palliative care*, advanced directives, and provide support.

9. Coordinate services such as home health, skilled nursing facilities, inpatient rehabilitation, hospice, durable medical equipment, transplants and more.

Your Policy may require you to engage in case management to be eligible for some services. An organ transplant is one example. If we determine that participating with case management is required for you to be eligible for a certain service, a WPS case manager will contact you directly. If you choose not to engage with case management when it is a Policy requirement, it may be determined that services are not covered. WPS case management services are available to members, and any member can contact WPS and request to engage with a nurse case manager for any care needs.

G. 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.

2. The provider's participation with us is terminated because of his/her misconduct.

This Subsection G. 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: (a) the applicable *deductible*; (b) the applicable *coinsurance*; (c) the applicable *copayment*; (d) your *out-of-pocket limit*; (e) exclusions; (f) our *prior authorization* requirements; (g) our *maximum allowable fee*; (h) all other limitations shown in your Schedule of Benefits; and (a) all other terms, conditions, and provisions of the Policy.

A. Deductible

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

When your *deductible* is satisfied, *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

When your *deductible* is satisfied, you will be responsible for the *coinsurance* amounts shown in your Schedule of Benefits. *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. Any applicable *copayments* will apply unless your *out-of-pocket limit* is satisfied.

You may have a *copayment* when you get a prescription filled. See section 5. JJ. (Covered Expenses / Prescription Legend Drugs and Supplies) for information about prescription *copayments*.

If you receive *health care services* at a *hospital*-based outpatient clinic or location, you may be billed two separate *charges* – one for the *health care practitioner* and one for the facility. For *health care services* other than emergency room care, the *copayment* only applies to the visit *charge* billed by the *health care practitioner*. *Charges* for the facility and related services are subject to the applicable *cost sharing* shown in your Schedule of Benefits. See section 5. R. (Covered Expenses / Emergency Medical Care) for information about emergency room *copayments*.

D. Out-of-Pocket Limits

Each *calendar year*, you are required to pay your applicable *cost sharing* up to the *out-of-pocket limits* shown in your Schedule of Benefits.

When your *out-of-pocket limit* is satisfied, *cost sharing* will not apply, and we will pay *benefits* up to the *maximum allowable fee* for covered *health care services* subject to all other terms, conditions, and provisions of the Policy.

The *preferred provider* and *non-preferred provider out-of-pocket limits* 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 out-of-pocket limit* shown in your Schedule of Benefits.

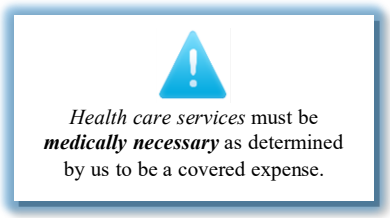
E. Maximum Allowable Fee

We'll pay *charges* for the *covered expenses* described in section 5. (Covered Expenses) up to the *maximum allowable fee* subject to your *cost sharing* as described above. If you receive *health care services* from 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.
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. C. (Obtaining Services / Prior Authorization) for detailed information about our *prior authorizations*. Additionally, all *benefits* are subject to the *cost sharing* 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. Alcohol and Other Substance Use Disorder 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.

Specific allergy testing is considered *medically necessary* when ALL of the following criteria are met:

1. The *covered person* has a clinically significant allergic history of symptoms.
2. Symptoms are not adequately controlled by empiric conservative therapy.
3. Testing correlates to the *covered person's* specific history, risk of exposure, and physical findings.
4. The test method and/or allergens tested have proven efficacy demonstrated through scientifically valid studies published in the peer-reviewed literature.

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.
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. **Covered Ambulance Services (Emergency and Non-Emergency):**

   a. Professional ground ambulance services provided by a licensed ambulance service using its licensed and/or certified vehicle which is designed, equipped, and used to transport you when you are sick or injured and is staffed by emergency medical technicians, paramedics, or other certified medical professionals for a *medical emergency*:

   1) From the site of a *medical emergency* to the nearest facility equipped to treat the *medical emergency.*

   2) From one facility to the nearest other facility equipped to provide *treatment* for your condition.

   3) When other means of transportation are considered unsafe due to your medical condition, the following professional ambulance services:

   a) From one facility to another facility for inpatient or outpatient treatment.

   b) From home to a facility.

   c) From a facility to home.

b. *Medically necessary* air ambulance services provided by a licensed ambulance service using its licensed and/or certified helicopter or plane which is designed, equipped, and used to transport you when you are sick or injured and is staffed by emergency medical technicians, paramedics, or other certified medical professionals for a *medical emergency*. Such services are eligible for coverage regardless of network status and you may not be balanced billed. Air professional ambulance services are covered only when all the following conditions are met:

1) Ground ambulance is not appropriate.

2) The situation is a *medical emergency*.

3) Air ambulance is *medically necessary*.

4) Transport is to the nearest facility able to provide the necessary *emergency medical care* as determined by us.

5) *Prior authorization* is obtained prior to any non-emergent transportation service being provided.

For additional information regarding coverage criteria please see:
https://www.wpshealth.com/resources/files/emergency-air-ambulance-services.pdf.

c. 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.

d. Ambulance services for emergency 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.

2. Excluded Ambulance Services:

a. When you can use another type of transportation without endangering your health.

b. When ambulance services are not *medically necessary*.

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. R. (Emergency Medical Care).

e. Ambulance services for personal or convenience purposes, including repatriation or transportation back to the continental United States.

f. Air ambulance services not ordered by, or after consultation with, a *health care practitioner* or requested by police or emergency services personnel at the location of the emergency.

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 below (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. (Excluded Autism Services), except for *durable medical equipment* and *prescription legend drugs*. Please see sections 5. Q. (Durable Medical Equipment) and 5. JJ. (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. 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 progress report developed by a qualified provider or professional as defined by state law that includes an average of twenty (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.

      4) Provided in an environment most conducive to achieving the goals of your progress report.

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

      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.

      4) The qualified therapist develops and implements a progress report 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: (1) 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 (2) 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 progress report and include specific therapy goals that are clearly defined, directly observed, and continually measured and that address the characteristics of autism spectrum disorders.

      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 progress report.

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.

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

2. Excluded Autism Services:

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. Childcare 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. *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*.

n. *Durable medical equipment* and pharmaceuticals.

G. Behavioral Health Services

1. Covered Behavioral Health Services:

Inpatient, residential, and transitional services require *prior authorization*.

a. Inpatient *hospital* services.

b. Outpatient services including *office visits.*

c. *Transitional treatment,* including any of the following *health care services* if provided by a *health care provider* certified by the Wisconsin Department of Health Services or, for out-of-state services and programs, the *health care provider* is in compliance with similar requirements of the state in which the *health care provider* is located:

1) *Day treatment programs*.

2) Community support programs.

3) Residential treatment programs.

4) Intensive outpatient programs.

5) 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.

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 Wisconsin Department of Health Services, or for out-of-state services and programs, the *health care provider* is in compliance with similar requirements of the state in which the *health care provider* is located.

2) The specific diagnosis is consistent with the symptoms.

3) The *transitional treatment* is standard medical practice and appropriate for the specific diagnosis.

4) The *transitional treatment* plan is focused for the specific diagnosis.

5) 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 *progress report* 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 Wisconsin Department of Health Services.

3. Excluded Behavioral Health Services:

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. SS. (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. 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. 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 Limitation:**

   Phase II cardiac rehabilitation is limited to thirty-six (36) sessions per covered *illness*.

3. **Excluded Cardiac Rehabilitation:**

   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.

   c. Phase II cardiac rehabilitation in excess of thirty-six (36) sessions per covered *illness*.

I. Chiropractic Services

For therapy *benefits*, please see section 5. SS (Therapy Services).

1. **Covered Chiropractic Services**:

   Medically necessary services and diagnostic tests provided by a *health care practitioner*.

2. **Excluded Chiropractic Services:**

   The Policy provides no *benefit* for chiropractic services which are considered *maintenance care* or *supportive care*. This exclusion applies in addition to the exclusions outlined in section 6. (General Exclusions).

J. Clinical Trials

Routine patient care costs you incur while participating in a *qualifying clinical trial* for any of the following:

1. Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
2. Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the *qualifying clinical trial* criteria.
3. Surgical musculoskeletal disorders of the spine, hip, and knees, which are not life threatening, for which, as we determine, a clinical trial meets the *qualifying clinical trial* criteria.
4. Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the *qualifying clinical trial* criteria.

Benefits include the reasonable and necessary incidental items and services used to prevent, diagnose, and treat complications arising from participation in a *qualifying clinical trial.* It does not include items and services needed due to the clinical trial.

Benefits are available only when you are clinically eligible for participation in the *qualifying clinical trial* according to the clinical trial protocol as defined by the researcher.

K. Cognitive Rehabilitation Therapy

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

L. Colorectal Cancer Screening and Diagnosis

Routine colorectal cancer screenings are covered as preventive screenings under section 5. KK. (Preventive Care Services). Diagnostic colorectal cancer tests are covered under section 5. P. (Diagnostic Services) and section 5. PP. (Surgical Services).

M. Contraceptives for Birth Control and Women's Health

FDA-approved contraceptives (drug and devices) prescribed by a *health care practitioner*, outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive; sterilization procedures for women; and patient education and counseling related to contraception for all women with reproductive capacity. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period and costs for breastfeeding equipment. Screening and counseling for interpersonal and domestic violence, 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. JJ. (Prescription Legend Drugs and Supplies) and male sterilization procedures are covered under section 5. PP. (Surgical Services).

N. Dental Services

For *oral surgery benefits* including oral reconstructive maxillofacial surgery, please see section 5. PP. (Surgical Services).

1. **Covered Dental Services**:
   - **a.** Dental repair or replacement of your *teeth* due to an accidental *injury* if the dental damage is severe enough to require initial contact with a *health care practitioner* or dentist within sixty (60) days of the accident, and *treatment* is provided by a Doctor of Dental Surgery (DDS) or Medical Dentistry.
   - **b.** Extraction of teeth: 1) in preparation of the jaw for radiation treatment of neoplastic disease; or 2) in preparation of a covered transplant.
   - **c.** Sealants on existing teeth to prepare the jaw for chemotherapy *treatment* of neoplastic disease.
   - **d.** *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.
       - **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 anesthesia for dental care.

2. Excluded Dental Services:

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). Please note that dental damage that occurs as a result of *activities of daily living* or extraordinary use of the teeth is not considered having occurred as an accident. *Benefits* are not available for repair to teeth that are damaged as a result of such activities.

a. Dental care (which includes dental x-rays, supplies and appliances and all associated expenses.

b. Hospital or surgery center facility charges incurred, and anesthetics provided in conjunction with dental care except as specifically stated in paragraph 1. d. above.

c. Dental care that is required to treat the effects of an *injury or illness*, but that is not necessary to directly treat the *injury or illness*. Examples include *treatment* of dental caries resulting from dry mouth after radiation *treatment* or as a result of medication.

d. Preventive care, diagnosis, *treatment* of or related to the teeth, jawbones, or gums. Examples include:

1) Medical or surgical *treatments* of dental conditions.

2) Services to improve dental clinical outcomes.

e. Dental implants, bone grafts and other implant-related procedures, except as specifically stated in paragraph 1. above.

f. Dental braces (orthodontics).

Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly.

O. Diabetes Services

For insulin, drugs and *supplies* used in the treatment of diabetes, please see section 5. JJ. (Prescription Legend Drugs and Supplies).

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 for *covered persons* requiring insulin or have a high risk of hypoglycemia (i.e., a major hypoglycemia risk factor or multiple other risk factors).

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.

d. Medical eye exams (dilated retinal examinations).

e. Foot care for *covered persons* with diabetes.

f. Diabetic self-management education programs.

g. Diabetic shoes when *medically necessary.*

2. Excluded Diabetes Services:

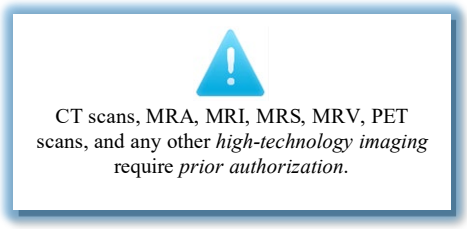
The Policy provides no *benefit* for the replacement of equipment unless *medically necessary* as determined by us. This exclusion applies in addition to the exclusions outlined in section 6. (General Exclusions).

P. 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, ultrasounds, Doppler imaging, electrocardiograms).

b. Laboratory services.

c. *High-technology imaging.*

2. Excluded Diagnostic Services:

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 or computer assisted navigation).

Q. Durable Medical Equipment

DME is only "durable" if it is prescribed by a *health care practitioner* for an *illness or injury* and is not useful to a *covered person* without an *illness or injury*. For additional information regarding coverage criteria please see https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf.

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, provided that the repairs are not covered under the warranty.

c. Replacement of *durable medical equipment* if such equipment cannot be restored to a serviceable condition or if warranty has expired, subject to approval by us.

d. Breastfeeding equipment in conjunction with each birth.

e. Oral appliance for sleep apnea. For additional information regarding coverage criteria please see: https://www.wpshealth.com/resources/files/sleep_disorder_treatment.pdf.

2. Durable Medical Equipment Limitations:

a. *Benefits* will be limited to the standard models, as determined by us.

b. If more than one type of *durable medical equipment* can meet a covered person's functional needs, coverage is limited to the type that meets the minimum specifications of the *covered person's* needs, as determined by us.

3. Excluded Durable Medical Equipment:

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.

c. *Durable medical equipment* that we determine to have special features that are not *medically necessary*.

d. *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.

e. Routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of a one-month rental billed every six (6) months.

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

g. Replacement of over-the-counter batteries.

h. Repairs or replacement due to abuse or misuse as determined by us.

i. Devices and computers to assist in communication and speech.

j. Enuresis alarms.

k. Duplicate *durable medical equipment* when you already have one of the same or similar *durable medical equipment,* except when that duplicate is deemed *medically necessary* as determined by us, or as required by law.

R. 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, as determined by us, such services from a *non-preferred provider* will be paid at the *non-preferred provider* level of *benefits*.

b. Covered *health care services* received from a *non-preferred provider* will be limited to the amounts that we determine to be the *qualifying payment amount*. You will not be responsible for the difference between the amount *charged* and the *qualifying payment amount*.

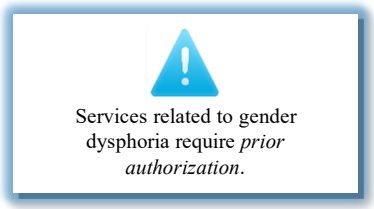
c. If an *ambulance service* is called and you are transported to an emergency room, coverage for any *emergency medical care* directly provided to you during your ambulance transport is payable under section 5. D. (Ambulance Services*)*. If an ambulance service is called, but you are not transported,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

3. Emergency Medical Care Received Outside of the United States:

a. If you receive *emergency medical care* 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.

b. Please see section 11. A. 1. (Claim Filing and Processing Procedures / Filing Claims / How to File a Claim for additional information).

S. Gender Dysphoria



Covered as defined in our corresponding medical policy and subject to state and federal law. For additional information regarding coverage criteria please see https://wpshealth.com/resources/files/treatment-of-gender-dysphoria.pdf.

T. Gene or Cell Therapy

1. Covered Gene or Cell Therapies:

Gene or cell therapies may be covered if ALL of the following are true:

a. *Treatment* is FDA-approved and determined to be *medically necessary* by us or our *delegate.*

b. All alternative standard-of-care *treatments* have been exhausted.

c. *Treatment* is administered by an approved *Gene or Cell Therapy Center of Excellence* facility.

2. Excluded Gene or Cell Therapies:

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). Gene or cell therapies may be excluded from coverage if **ANY** of the following are true:

a. Treatment does not match an FDA-approved indication, is the subject of an ongoing clinical trial, or is determined to be experimental/investigational/unproven as determined by WPS or subject matter expert; or

b. Alternative standard-of-care treatments have not been tried; or

c. Treatment is administered by a non-approved center of excellence facility.

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,* outside the diagnosis of cancer, must describe how and why, based on the results for the *genetic testing* results, your individual progress report would be different than your current or expected progress report 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. For additional information regarding coverage criteria please see https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf.

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. 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 For additional information regarding coverage criteria, please see : https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf. Please note that many molecular tumor profiling tests and gene-related or panel tests are not covered.

g. BRCA testing for a *covered person.* For additional information regarding coverage criteria please see https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf.

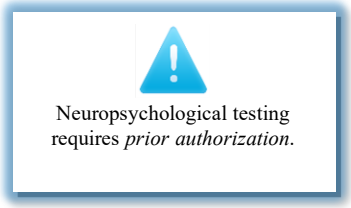
h. All other *genetic testing* for which you receive our *prior authorization*.

2. Excluded Genetic Services:

The Policy provides no *benefits* for any of the items listed in our medical policy. For information regarding Policy exclusions please see https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf.

V. Health and Behavior Assessments

1. Covered Health and Behavior Assessments:



a. Health and behavior assessments and reassessments.

b. Diagnostic interviews.

c. Neuropsychological testing up to ten (10) hours per *calendar year*. For additional information regarding coverage criteria please see: https://www.wpshealth.com/resources/files/neuropsych-testing.pdf.

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

2. Excluded Health and Behavior Assessments:

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 in an asymptomatic person, ImPACT® Immediate Post-Concussion Assessment and Cognitive Testing.

c. Greater than ten (10) hours of testing per *calendar year* requires a review by our Medical Director.

W. Hearing Services

This section 5. W. only applies to *covered dependent children* who are under age eighteen (18).

1. Covered Hearing Services:

Any of the following, provided the *covered dependent child* is under age eighteen (18) and certified as deaf or hearing impaired by a *health care practitioner,* and the *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, once every three years.

b. *Implantable hearing devices*, such as *cochlear implants* and *bone anchored hearing aids*.

c. Batteries and cords for *implantable hearing devices*.

d. *Treatment* related to *hearing aids* and *implantable hearing devices* covered under this subsection, including procedures for the implantation of *implantable hearing devices.*

e. Post-*cochlear implant* aural therapy.

2. Hearing Services Limitation:

Benefits will be limited to standard models as determined by us.

3. Excluded Hearing Services:

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. Non-implanted *hearing aid* batteries and cords.

c. *Hearing aids*, *implantable hearing devices* and related *treatment* provided to a *covered person* age eighteen (18) or over.

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 progress report.

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*.

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 Services Limitations:

a. *Benefits* are limited to sixty (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 (4) 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. Excluded Home Care Services:

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.

Z. Hospice Care

1. Covered Hospice Care Services:

a. *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, and the request is received from a hospice agency that is an appropriately licensed entity within the state the care is provided.

b. *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*.

2) *Hospice care* is a cost-effective alternative, as determined by us.

c. *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.

3) Services provided to you at your place of residence.

2. Excluded Hospice Care Services:

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 1. a. above.

AA. Hospital Services

Coverage and reimbursement shall comply with state and federal law, as required by state or federal law.

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. **Excluded Hospital Services:**

   These exclusions apply in addition to the exclusions outlined in section 6. (General Exclusions). The following are not covered under this section 5. AA.:

   a. *Transplant services.*

   b. Outpatient physical, speech, or occupational therapy.

   c. Services for the *treatment* of *substance use disorders* and/or *nervous or mental disorders.*

   Please see the following locations respectively for coverage information of the above:

   - Section 5. G. (Behavioral Health Services).
   - Section 5. SS. (Therapy Services).
   - Section 5. TT. (Transplant Services).

   d. *Confinement* in a *hospital* if care could safely and effectively be provided to you in a less acute setting

BB. 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. TT. (Transplant Services).

CC. 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 as required by the Women's Health and Cancer Rights Act of 1998:

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.
4. *Treatment* of physical complications for all stages of mastectomy, including lymphedemas.

DD. Maternity Services

For breastfeeding equipment *benefits* please see section 5. Q. (Durable Medical Equipment).

1. **Covered Maternity Services:**

   a. Any of the following maternity services when they are provided by a *hospital* or *health care practitioner*, when provided to a *covered person* or a *covered person* who is a surrogate:

   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 twenty-eight (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.*

b) Due to rape or incest.

c) Due to a *lethal fetal anomaly*.

d) The abortion procedure is permitted by and performed in accordance with law.

b. With respect to *confinements* for pregnancy, as required by federal law, the Policy will not limit the length of stay to less than:

1) 48 hours for a normal birth.

2) 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.

2. Excluded Maternity Services:

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. 5) above.

c. Fees charged for using a surrogate, except as specifically stated in paragraph 1. a. above.

d. Home births.

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

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

EE. Medical Services

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

2. Advance care planning office consultations limited to one initial consultation and two follow-up consultations.

3. *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. EE. do not include *health care services* covered elsewhere in the Policy, including *home care* services covered under Section 5. X. (Home Care Services).

FF. Medical Supplies

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

a. *Medically necessary* strapping and crutches, as determined by us.

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*.

d. Elastic stockings or supports when prescribed by a *health care practitioner* and required in the *treatment* of an *illness* or *injury*. For additional information regarding coverage criteria please see https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf.

e. Enteral therapy *supplies.*

f. Urinary catheters and *supplies*.

2. Excluded Medical Supplies:

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 supplies such as ace bandages, gauze, and dressings.

GG. Nutritional Services

1. Covered Nutritional Services:

a. Nutritional counseling that is: (1) for *treatment* of an *illness* or *injury* which requires nutritional counseling; and (2) provided by a *health care practitioner*, dietician or nutritionist licensed in the state where the counseling is provided to you.

b. Medical nutritional education services that are provided by an appropriately licensed or registered health care professional when **both** of the following are true:

1) Nutritional education is required for a disease in which patient self-management is an important component of *treatment*.

2) There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2. Excluded Nutritional Services:

a. Individual and group nutritional counseling billed as educational services, except as noted in section 5. KK. (Preventive Care Services).

b. Enteral feedings, even if the only source of nutrition.

c. Infant formula and donor breast milk.

d. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

HH. Orthotics

For additional information regarding coverage criteria please see https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf.

1. Covered Orthotics: *Orthotics* (including fittings, adjustments, and repairs) prescribed by a *health care practitioner,* such as but not limited to:

a. Casts and splints.

b. Orthopedic braces, including necessary adjustments to shoes to accommodate braces.

c. Cervical collars.

d. Corsets (back and special surgical).

e. Orthotics to support the foot when they are a permanent part of an orthopedic leg brace.

f. *Orthotics* to support the foot when custom-molded to fit the *covered person.*

g. Orthopedic shoes.

h. Over-the-counter *orthotics* to support the foot when prescribed by a *health care practitioner*.

2. Orthotics Limitations:

a. *Benefits* will be limited to standard devices as determined by us.

b. Orthopedic shoes are limited to one (1) pair per *covered person* per *calendar year*.

c. *Orthotics* may be replaced once per *calendar year* per *covered person* if *medically necessary*. Additional replacements will be allowed:

1) If you are under age nineteen (19) and due to rapid growth.

2) When the *orthotic* is damaged and cannot be repaired.

3. Excluded Orthotics:

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 and cleaning.

b. Repairs or replacement due to abuse or misuse as determined by us.

II. Pain Management Treatment

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

JJ. 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.

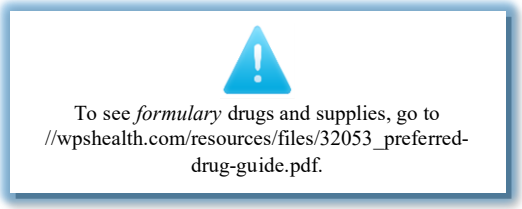
2. Covered Supplies.

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.

g. Glucose control solution.

3. **Our Discretion.** We have full discretionary authority to cover drugs or supplies that vary from the *benefits* described in the Policy.

4. **Cost Sharing.** See your Schedule of Benefits for information about *cost sharing* 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 *cost sharing* amount for each separate *prescription order* or refill of a covered drug or covered supply.

5. **Prescription Legend Drugs and Supplies Limitations.**

   a. If You Do Not Choose a Preferred Pharmacy. If drugs and supplies are dispensed to you by a pharmacy other than a *preferred 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 *cost sharing* and any difference between our *benefit* payment and the price you paid for the covered drug or supply.

   b. Step Therapy. If there is more than one *formulary 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 *formulary prescription legend drug* or complete a trial of traditional medical management. Alternatively, we may require you to try the less expensive *formulary prescription legend drug(s)* before *benefits* are payable for any other alternative *formulary prescription legend drug(s)*. Step therapy does not apply to *non-formulary drugs,* although trials of *formulary prescription legend drugs* may be required prior to coverage of a *non-formulary drug*.

   c. SaveOnSP Specialty Drug Program. Your plan includes a copay assistance benefit administered by Save On SP, LLC (SaveOnSP). You may have to satisfy your *deductible* first before this benefit begins. See your Schedule of Benefits for this information.

   Under this copay assistance benefit, certain *specialty drugs* on the Copay Assistance Benefit Drug List have been classified as non-essential health benefits (NEHBs). An NEHB classification does not mean these drugs are not important to you, this is a classification under the Affordable Care Act. A list of these SaveOnSP *specialty drugs* and the applicable coinsurance can be accessed at https://www.wpshealth.com/resources/files/35619_wps-esi-saveonsp-specialty-drug-list.pdf. This list will change from time to time. See your Schedule of Benefits for the applicable *coinsurance* for the SaveOnSP *specialty drugs*.

   If your *health care practitioner* prescribes you one of these NEHB drugs, SaveOnSP will contact you to participate in the plan's copay assistance benefit. Once you enroll in the available manufacturer copay assistance program and provide SaveOnSP with consent to monitor your pharmacy account, you will not have any cost sharing responsibility for that SaveOnSP *specialty drug.*

   In the event you fail to enroll in the applicable manufacturer copay assistance program, and/or you do not provide consent to SaveOnSP to monitor your pharmacy account, you will be responsible for the full required *coinsurance* for the NEHB drugs even after your *out-of-pocket limit* has been satisfied.

   Any *coinsurance* paid for these medications (either paid by you or by the manufacturer copay assistance program) will not apply to any applicable *out-of-pocket limit*. Additionally, as a result of the NEHB classification, the *coinsurance* will continue even after you've met your plan's *out-of-pocket limit*.

   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,* drugs administered by a *health care provider*, and *non-formulary drugs*. To determine whether a *formulary* 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.

A request for a *non-formulary drug* or to bypass a *step therapy* requirement would be considered an *exception* to the *benefit* and would require a *prior authorization*. To determine whether a drug is a *formulary drug* or a *non-formulary drug*, please call the telephone number shown on your identification card.

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 interchangeable *biosimilar*) is available, you must pay the difference in cost between the drug obtained and its equivalent plus the applicable *cost sharing* amounts. The cost difference is not applied toward your *out-of-pocket limit* including *copayments/deductibles/coinsurance* and the cost difference will continue to apply after your *out-of-pocket limit* has been satisfied. 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 JJ. 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.

Item	Quantity Limit
Prescription legend drugs or supplies, including non-specialty *biosimilar* drugs, dispensed by a *retail pharmacy*	Up to a 90-day supply for maintenance drugs per fill or refill; and up to a 30-day supply for all others per fill or refill
Prescription legend drugs (other than *specialty drugs*) or supplies dispensed by a *home delivery pharmacy*	Up to a 90-day supply per fill or refill
Preventive drugs used for Tobacco Cessation	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
Specialty drugs and specialty *biosimilar* drugs	Up to a 30-day supply per fill or refill, except as noted above
Blood glucose monitor dispensed by a pharmacy	One per *covered person* per *calendar year*

g. Limitations on Covered Drugs and Covered Supplies. If we determine a *prescription legend drug* or supplies can safely be obtained from and/or administered in a lower-cost or lower intensity 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* or supplies purchased from and/or administered by a *health care provider* in a higher-cost or higher intensity 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 or higher intensity place of service in certain limited circumstances (for example teaching/training purposes).

h. **Miscellaneous:** If the *charges* for a *prescription legend drug* is reduced by a manufacturer promotion (e.g., coupon, *copayment* assistance, or rebate), we may take that reduction into account when calculating the *cost sharing*, including the amount applied to your *deductible* or *out-of-pocket limit*.

6. Excluded Prescription Legend Drugs and Supplies.

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. Hormone replacement 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, forgotten, stolen, spilled, spoiled, damaged, or otherwise rendered unusable whether dispensed by a *retail pharmacy*, *home delivery pharmacy*, or *specialty pharmacy*. This exclusion does not apply to prescription eye drop refills.

k. Any drug, supply, or device that is available over the counter or 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. Any drug that is FDA approved and used to reduce appetite or for weight control or whose primary use is appetite reduction or weight control.

n. Any compounded drug that is substantially like a commercially available product unless the commercially available product is subject to a manufacturers shortage as reported by the FDA.

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

p. Any drug prescribed to treat sexual dysfunction or to enhance sexual activity.

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. Any *non-formulary drug* for which *prior authorization* is not obtained.

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

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.

w. Medical marijuana or any non-legend drug containing cannabidiol (CBD), tetrahydrocannabinol (THC), and/or other derivatives of the cannabis sativa plant.

KK. Preventive Care Services

Preventive care services are covered to the extent required by state and federal law and are provided on an outpatient basis at a *health care practitioner's* office or *hospital* and that have been: (1) demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease; and (2) proven to have a beneficial effect on health outcomes.

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.

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

c. 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.

d. 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.

e. The following additional *preventive care services* as determined by us:

1) Breast cancer screening coverage is increased to include one routine mammogram of a *covered person* per *calendar year* without age limits.

2) Cervical cancer screening coverage is increased to include screenings without age or frequency limitations.

3) Blood lead tests.

4) Colorectal cancer screening coverage is increased to include one colonoscopy or one sigmoidoscopy in a five-year period. Any additional routine sigmoidoscopies or colonoscopies performed within that five-year period shall be payable under section 5. PP. (Surgical Services) subject to applicable *cost sharing*.

5) Eye exams with or without refraction not subject to age or frequency limitations.

2. Preventive Care Services Limitation:

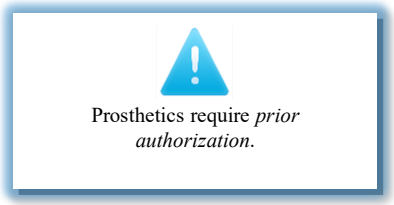
Some *office visits* and laboratory and diagnostic studies may be subject to *cost sharing* if those services are not part of a routine preventive or screening examination. For example, when you have a symptom or history of an *illness* or *injury*, *office visits* and laboratory and diagnostic studies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

3. Excluded Preventive Care Services:

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

LL. Prosthetics

For additional information regarding coverage criteria please see https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf.



1. **Covered Prosthetics**:

   a. Prosthetic devices and related *supplies,* including the fitting of such devices, which replace all or part of:

      1) An absent body part (including contiguous tissue).

      2) The function of a permanently inoperative or malfunctioning body part.

   b. External prosthetic devices that replace a limb or any body part, limited to:

      1) Artificial arms, legs, feet, and hands.

      2) Artificial face, eyes, ears, and nose.

      3) Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm. Benefits under this subsection 3) are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

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

2. **Excluded Prosthetics:**

   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 and any other prosthetics not mentioned in 1. b. (above).

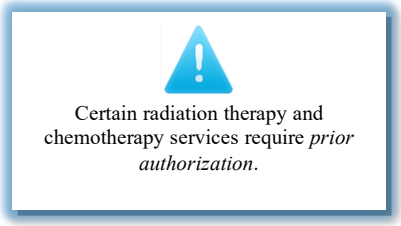
   c. Repairs or replacement due to abuse or misuse as determined by us.

MM. Pulmonary Rehabilitation

Outpatient pulmonary rehabilitation therapy limited to twenty-four (24) visits per covered *illness*. No other *benefits* for outpatient pulmonary rehabilitation therapy are available under the Policy.

NN. Radiation Therapy and Chemotherapy Services

Radiation therapy and chemotherapy services. *Benefits* are also payable for *charges* for image guidance, radium, radioactive isotopes and chemotherapy drugs and *supplies* used in conjunction with radiation therapy and chemotherapy services.



OO. Skilled Nursing Care in a Skilled Nursing Facility

1. **Covered Skilled Nursing Care:**

   Skilled nursing care provided to you during your *confinement* in a *skilled nursing facility* if both are true:

   a. 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.

   b. Care is *medically necessary* as certified by the attending *physician* every seven days and is for continued *treatment* of the same *illness* or *injury* treated in the hospital (as per the Wisconsin mandated benefit).

2. **Skilled Nursing Care Limitations:**

   a. *Skilled nursing care* is limited to thirty (30) days per *confinement* per *covered person*.

   b. Each day of your *confinement* will count towards this thirty (30)-day limit, regardless of whether the *charges* are applied to your *deductible* or paid by us under the Policy.

3. **Excluded Skilled Nursing Care:**

   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*, as defined in section 5. X. (Home Care Services), 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 https://docs.legis.wisconsin.gov/statutes/statutes/49/title).

PP. Surgical Services

This section 5. PP. does not include *surgical services* for: (1) covered transplants or (2) pain management procedures. Please see section 5. II. (Pain Management Treatment), and section 5. TT. (Transplant Services) 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:

   Spinal surgery and certain other surgeries require *prior authorization*.

   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.

      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*.

   c. *Oral surgery*, including related consultation, x-rays or other necessary imaging, and anesthesia, is limited to the following procedures:

      1) Surgical removal of impacted, unerupted teeth.

      2) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

      3) Surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

      4) Apicoectomy (excision of the apex of the tooth root).

      5) Root canal therapy, if performed simultaneously with an apicoectomy.

      6) Excision of exostosis (bony outgrowth) of the jaws and hard palate.

      7) Frenotomy (incision of the membrane connecting the tongue to the floor of the mouth.

      8) Incision and drainage of cellulitis (tissue inflammation) of the mouth.

      9) Incision of accessory sinuses, salivary glands, or ducts.

10) Gingivectomy (excision of gum tissue to eliminate infection) but not including restoration of gum tissue or soft tissue.

11) Alveolectomy.

12) Orthognathic surgery.

13) Oral reconstructive maxillofacial surgery.

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 biopsy proven diagnosis of Anaplastic Large Cell Lymphoma.

2. Excluded Surgical Services:

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. *Oral surgery*, except as specifically stated in paragraph 1. c. above.

c. *Reconstructive surgery* for purposes other than to correct *functional impairment*.

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

e. Transoral incisionless fundoplication procedures.

QQ. Telemedicine Services

1. Covered Telemedicine Services:

Telemedicine services provided by a *health care practitioner* to a *covered person* via telephone or interactive audio-visual telecommunication to treat a covered *physical illness, nervous or mental disorder, substance use disorder,* or *injury*.

NOTE: *Telemedicine* services provided by our designated telehealth service provider are covered as stated in your Schedule of Benefits. 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. Excluded Telemedicine Services:

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.

c. Telecommunications, including but not limited to instant messaging, text messaging, email communication, or facsimile communication.

RR. Temporomandibular Joint (TMJ) Disorder Services

For additional information regarding coverage criteria please see https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf.

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.

   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. **Excluded TMJ Disorder Services:**

   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.

SS. Therapy Services

1. **Covered Therapy Services subject to limitations:**

   a. Physical therapy when billed as *rehabilitative services* or *habilitative services*. This includes aquatic therapy provided and billed by a physical therapist.

   b. Speech therapy when billed as *rehabilitative services* or as *habilitative services*.

   c. Occupational therapy when billed as *rehabilitative services* or as *habilitative services.* This includes aquatic therapy provided and billed by an occupational therapist.

   d. Massage therapy when provided and billed by a chiropractor, physical therapist, or occupational therapist.

2. **Therapy Services Limitations:**

   a. Outpatient *therapy visits* are limited to a combined total of twenty-five (25) visits per *calendar year* per *covered person* for the following:

   1) Physical therapy, including aquatic therapy, when billed as *rehabilitative services* or *habilitative services*.

   2) Speech therapy when billed as *rehabilitative services* or as *habilitative services*.

   3) Occupational therapy, including aquatic therapy, when billed as *rehabilitative services* or as *habilitative services.*

   b. Massage therapy limited to six (6) visits per *calendar year* per *covered person*. This limit does not apply to massage therapy when provided by a chiropractor.

   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*. 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.

3. **Excluded Therapy Services:**

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. RR. (Temporomandibular Joint (TMJ) Disorder Services).

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

c. Therapy services provided by a massage therapist.

TT. Transplant Services

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* as determined by us during the *prior authorization* process for an *illness* or *injury*.

c. All organ transplants must be performed at a *designated transplant facility* that is designated as a *Center of Excellence*. If a *Center of Excellence* is not available within 120 miles of *your* residence, then a *designated transplant facility* that is designated as a *Transplant Access Program* facility will be approved.

d. *Transplant services* are subject to any *cost sharing* amounts shown in your Schedule of Benefits.

2. **Covered Transplant Services (Including Kidney Transplants):**

Health care services for approved transplants when ordered by a *health care practitioner*, including, but not limited to:

a. *Hospital charges*.

b. *Health care practitioner charges*.

c. *Organ and tissue acquisition* (including related medical expenses of a living donor).

d. Tissue typing.

e. Ancillary services.

f. Post-transplant complications if you are the recipient.

g. Post-harvesting complication if you are a donor.

h. Covered *transplant drugs* as described in section 5. JJ. (Prescription Legend Drugs and Supplies).

3. **Excluded Transplant Services:**

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.

e. Any organ transplant performed at a *non-designated transplant facility*.

UU. Vision Services - Non-Routine

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 aphakia, keratoconus, or following cataract surgery.

d. Orthoptic therapy and pleoptic therapy (eye exercise) for *treatment* of strabismus and convergence insufficiency.

2. Excluded Vision Services:

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, including, but not limited to radial keratotomy and laser in-situ keratomileusis (also known as Lasik).

c. Preparation, fitting or purchase of eyeglasses or contact lenses, except as specifically stated above.

d. Correction of visual acuity or refractive errors by any means, except as specifically stated above.

e. Implantable specialty lenses, including, but not limited to, toric astigmatism-correcting lenses and multifocal presbyopia-correcting intraocular lenses to improve vision following cataract surgery.

f. Orthoptic therapy and pleoptic therapy (eye exercise) except as stated in paragraph 1. d. above.

VV. Vision Services - Pediatric

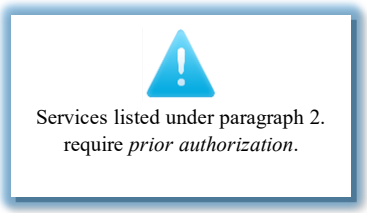
1. Pediatric vision services as listed below for a *covered person* until the last day of the month in which he/she reaches age nineteen (19):

a. Single vision, conventional (lined) bifocal, or conventional (lined) trifocal prescription lenses limited to one (1) pair per *covered person* per *calendar year*. Lenses include the choice of glass, plastic, or polycarbonate and will include scratch resistant coating.

b. Frames limited to one (1) frame per *covered person* per *calendar year*.

c. Contact lenses when purchased in lieu of all other frames and/or lenses. *Benefits* are limited to forty-eight (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.

7) Irregular astigmatism.

b. Low vision services including the following:

1) One (1) comprehensive low vision evaluation every five (5) years.

2) Low vision aids, limited to the following:

a) Spectacles.

b) Magnifiers.

c) Telescopes.

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.

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. JJ. (Covered Expenses / Prescription Legend Drugs and Supplies):

a. Investigational drugs for the *treatment* of HIV infection as described in Wis. Stat. § 632.895(9).

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 / Workers' 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, or would be covered by, Medicare as the primary payer if you are eligible for Medicare. This applies regardless of whether you are actually 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.

    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*, *qualifying payment amount* or *maximum out-of-network allowable fee.*

13. Chelation therapy, except in the *treatment* of heavy metal poisoning.

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* directly related to any *health care service* not covered under this policy. This includes any services resulting from or arising from the complications of a non-covered service and also services required to perform the non-covered service. The only exception is services resulting from or arising from the complications of, or incidental to, a *subscriber's* or his/her spouse's or *domestic partner's* elective abortion.

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) for cosmetic purposes.

g. Hair removal unless part of an approved procedure.

h. Mastopexy unless part of an approved procedure.

i. Augmentation mammoplasty (except for reconstruction associated with a covered mastectomy or covered gender reassignment surgery).

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. Labiaplasty.

q. *Treatment* of sialorrhea (drooling or excessive salivation).

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.

c. In the non-operative partial removal of toenails.

This exclusion does not apply to *medically necessary health care services* that are incidental to a covered *illness* or *injury*, as determined by us.

29. Housekeeping, shopping, or meal preparation services.

30. *Health care services* provided in connection with any *illness* or *injury*:

a. Caused by your engaging in an illegal occupation.

b. 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. *Health care services* for the *treatment* of weak, strained, flat, unstable, or unbalanced feet except as specifically stated sections 5. O. (Covered Expenses / Diabetes Services) and 5. HH. (Covered Expenses / Orthotics).

36. *Health care services* for *treatment* of sexual dysfunction, including impotence, regardless of the cause of the dysfunction. This includes:

- **a.** S*urgical services*.
- **b.** Devices.
- **c.** Penile implants.
- **d.** Sex therapy.
- **e.** *Prescription legend drugs*.

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. Stem cell therapy.

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

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

46. Car seats.

47. 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.

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

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

50. *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.

51. Hypnosis.

52. Acupuncture.

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. H. (Covered Expenses / Cardiac Rehabilitation Services) and 5. SS. (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. KK. (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 that is FDA approved and 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.

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).

64. *Health care services* associated with *charges* for *infertility* or *fertility treatment*, including assisted reproductive technology, donor eggs, donor sperm, host uterus, storage, and retrieval of all reproductive materials (including but not limited to eggs, sperm, testicular tissue, and ovarian tissue) and reversal of voluntary sterilization. This exclusion does not apply to *health care services* required to treat or correct underlying causes of *infertility*.

65. Direct attempts to achieve pregnancy or increase chances of achieving pregnancy by any means. This exclusion does not apply to *health care services* required to treat or correct underlying causes of *infertility*.

66. Any laparoscopic procedure during which an ovum is manipulated for the purpose of fertility *treatment* even if the laparoscopic procedure includes other purposes. This exclusion does not apply to *health care services* required to treat or correct underlying causes of *infertility*.

67. Prescription or non-prescription formula, food, food supplements, or vitamins, whether taken orally or enterally (tube feeding), unless required by law.

68. Over the counter *digital therapeutics* such as, but not limited to, Fitbit, smart watch, Apple watch, whether with or without a prescription.

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.

   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*.

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.

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.

   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.

   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 sixty-five (65) or older and is covered under an employer group health plan of an employer that employs at least twenty (20) persons (including part time employees) for a minimum of twenty (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 sixty-five (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% 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 thirty (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 eligible for Medicare as your primary *plan*, this Policy will not cover any expense that Medicare would cover regardless of whether you are actually enrolled in Medicare, except for kidney disease treatment, limited to dialysis, transplantation, and donor-related services.

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 last day of the calendar month 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 day before you enter into military service, other than for an assignment of less than thirty (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 unless a later date is specifically stated in the employer's leave of absence policy. Such leave of absence policy and any supporting documentation must be provided to us upon our request.

   c. 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 (such date must be the last day of the calendar month).

8. For a *subscriber's covered dependent*, the last day the *subscriber* has coverage.

9. For a *subscriber's* spouse or *domestic partner* who is a *covered person*: (a) the last day the *subscriber's* spouse is married to the *subscriber* when the marriage ends due to divorce or annulment; or (b) the last day the *domestic partner* 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 twenty-six (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 stepchildren, the last day the *subscriber's* spouse is married to the *subscriber* when the marriage ends due to divorce or annulment.

c. For a *child* of a *domestic partner*, the last day the *subscriber's domestic partner* meets the definition of an *eligible dependent*.

11. For a child of a *covered dependent child* (i.e., the *subscriber's* grandchild), the day before the *subscriber's child* reaches age eighteen (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. The day he/she advises us that he/she does not intend to return to school full-time.

2. The day before he/she becomes employed full time.

3. The day before he/she obtains other health care coverage.

4. The day before 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.

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 **all** of the following are true:

1. The *child's* coverage under the Policy began before he/she reached age twenty-six (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 twenty-six (26).

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 twenty-six (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 twenty-eight (28), we may request poof 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 day 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.*

   b. *Confined* in a *hospital*.

   An extension of *benefits* provided under this Subsection D. will end on the earliest of the following dates:

   a. The day you are no longer *totally disabled* or no longer *confined* in a *hospital*.

   b. The day on which 12 consecutive months have passed since the date the Policy ended.

   c. 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* to*tal 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 the identity of a *covered person* to obtain *health care services.*
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.

   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.

   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 thirty (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.

   f. Eighteen (18) consecutive months after you elect continuation coverage.

4. If any of the 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 want 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 are 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.

    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 dependent*s. *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*.

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 thirty (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 *treatment*s (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 practitioner*.

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 progress report 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 *illness*es 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.

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.

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.

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.

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

P*rescription 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 Appeals 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 twenty-four (24) hours after receipt of your request provided that the request is submitted to us at least twenty-four (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 seventy-two (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 twenty-four (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 twenty-four (24) hours after we receive the *incomplete claim*. You will then have forty-eight (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 five (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 fifteen (15) days after our receipt of a *pre-service claim*. However, this period may be extended one time by an additional fifteen (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 fifteen (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 forty-five (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 twenty-five (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 seventy-five (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 thirty (30) days after our receipt of a *post-service claim*.

   However, this period may be extended one time by an additional fifteen (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 fifteen (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 forty-five (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 forty (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 ninety (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.

WPS Health Insurance
Grievance and Appeals Department
P. O. Box 7062
1717 West Broadway
Madison, WI 53707-7062
Fax Number: 608-327-6319

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 a *durable medical equipment*, or other medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay *benefits* for that *prescription legend drug*, *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 days 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:

WPS Health Insurance
Grievance and Appeals Department
P. O. Box 7062
1717 West Broadway
Madison, WI 53707-7062
Phone: 920-490-6987 or
Phone: 877-897-4123 (toll-free)
Fax Number: 608-327-6319

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 (6) 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 *medical 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 (6) 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* want 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*.

WPS Health Insurance
Attention: IRO Coordinator
P.O. Box 7062
Madison, WI 53707-7062
Fax: 608-327-6319

Your request for an independent external review must include:

A. Your name, address, and telephone number.

B. An explanation of why you believe that the *treatment* should be covered.

C. Any additional information or documentation that supports your position.

D. If someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative.

E. Any other information 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 forty-five (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:

A. Bathing which is the cleansing of the body in either a tub or shower or by sponge bath.

B. Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs.

C. Toileting, which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene.

D. Mobility, which is to move from one place to another, with or without assistance of equipment.

E. Eating, which is getting nourishment into the body by any means other than intravenous.

F. 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 made by us to which **all** of the following apply:

A. We have reviewed admission to a health care facility, the availability of care, the continued stay or other *treatment*.

B. Based on the information provided, the *treatment* does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.

C. Based on the information provided, we reduced, denied, or terminated the *treatment* or payment of the *treatment*.

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

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*. An interchangeable biosimilar may be substituted without the intervention of the *health care provider* who prescribed the reference product, much like how *generic drugs* are routinely substituted for *brand-name drugs*.

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:

A. Used within the context of an FDA-approved clinical trial.

B. Used according to the clinical trial's approved protocols.

C. Fall under a covered *benefit* category and not excluded by law, regulation, or current Medicare coverage guidelines.

D. *Medically necessary* for the *covered person*, and the amount, duration and frequency of use or application of the service is medically appropriate.

E. Furnished in a setting appropriate to the *covered person's* medical needs and condition.

Center of Excellence: a *designated transplant facility* that is defined by our transplant network as having met the highest standards of quality, satisfaction, and affordability for a specific type of organ transplant.

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:

A. A biological child of a *subscriber*.

B. A stepchild of a *subscriber*.

C. A legally adopted child or a child *placed for adoption* with the *subscriber*.

D. A child solely under the *subscriber's* (or his/her spouse's) court-ordered legal guardianship as determined by us.

E. A child who is considered an alternate recipient under a qualified medical child support order. See section 2. E. 6. (Eligibility, Enrollment, and Effective Date / Special Enrollment Periods / Child Support Order) for additional information about child support orders.

F. The child of a *subscriber's domestic partner* provided that:

1. The *domestic partner* is enrolled as a *covered person* under the Policy.

2. 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:

A. Is located in a retail store, supermarket, pharmacy, or other non-traditional, convenient, and accessible setting.

B. 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:

A. The applicable copayment.

B. The *charge* for the *covered expense*.

Correctly Filed Claim: a claim that includes **all** of the following:

A. The completed claim forms that we require.

B. The actual itemized bill for each *health care service*.

C. All other information that we need to determine our liability to pay *benefits* under the Policy, including but not limited to, medical records and reports.

Cosmetic Treatment: any *health care service* used solely for one or both of the following:

A. To change or improve your physical appearance or self-esteem.

B. For *treatment* of a condition that causes no *functional impairment* or threat to your health.

Cost Sharing: Your share of costs for *health care services* covered under the Policy that you must pay out of your own pocket limited to *copayments*, *deductibles*, and *coinsurance*. Other costs, including your premiums, amounts you pay for non-covered *health care services*, and amounts you pay that exceed the *maximum allowable fee* are not considered cost sharing.

Covered Dependent: an *eligible dependent* who has properly enrolled and been approved by us for coverage under the Policy.

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

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

Covered Person: a *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:

A. Non-health-related services, such as assistance in *activities of daily living*.

B. 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.

C. 24-hour supervision for potentially unsafe behavior.

D. Supervision of medication which usually can be self-administered.

E. 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:

A. You are under the care of a *health care practitioner*.

B. The *health care practitioner* prescribes *health care services* to support and maintain your physical and/or mental condition.

C. Services are being provided by a nurse.

D. Such care involves the use of technical medical skills if such skills can be easily taught to a layperson.

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

Deductible: the specified amount you are required to pay for *covered expenses* in a *calendar year* before *benefits* are payable under the Policy. You may have a separate deductible for *prescription legend drugs* and supplies purchased from a pharmacy. Your deductible amounts are shown in your Schedule of Benefits.

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 all of the following:

- **A.** Approved by us to be the most appropriate facility for your approved *transplant services.*
- **B.** Contracted to provide approved *transplant services* to *covered persons* pursuant to an agreement with one of our transplant provider networks.
- **C.** Designated as a *Center of Excellence* for the specific organ transplant or as a *Transplant Access Program*.

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).

Digital Therapeutics (DTx): software-based *treatments* that use evidence-based methods to prevent, manage, or treat medical conditions. DTx can be used alone or in combination with other *treatments*, such as medications or in-person therapy.

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:

- **A.** 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*.
- **B.** Each partner is eighteen (18) years of age or older.
- **C.** Neither partner is married or legally separated in marriage or has been a party to an action or proceeding for divorce or annulment within six (6) months of registration, or, if one has been married, at least six (6) months have lapsed since the date of the judgment terminating the marriage.
- **D.** Each partner is competent to contract.
- **E.** Neither partner is currently registered in another domestic partnership, and if either party has been in such a registered relationship, at least six (6) months have lapsed since the effective date of termination of that registered relationship.
- **F.** There are no blood ties between the *subscriber* and his/her partner closer than that permitted for marriage or for domestic partner registration.
- **G.** 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).
- **H.** 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:
  - **1.** Joint lease, mortgage, or deed.
  - **2.** Joint ownership of a vehicle.
  - **3.** Joint ownership of checking account (demand deposit) or credit account.
  - **4.** Designation of the partner as a beneficiary of the *subscriber's* will.
  - **5.** Designation of the partner as a beneficiary for the *subscriber's* life insurance or retirement benefits.
  - **6.** Designation of the partner as holding power of attorney for health care.
  - **7.** Shared household expenses.

Drug Deductible: the specified amount you are required to pay for covered prescription legend drugs and supplies dispensed by a *retail pharmacy*, *home delivery pharmacy* or *specialty pharmacy* in a *calendar year* before *benefits* are payable under the Policy. Your drug deductible amount (if applicable) is shown in your Schedule of Benefits.

Durable Medical Equipment (DME): medical equipment designed for repeated use at home for a prolonged period, i.e., wheelchairs, walkers, oxygen tanks, and hospital beds, and is prescribed by a *health care practitioner* for an *illness* or *injury.* It must be durable to withstand repeated use and is considered *medically necessary* for *activities of daily living* for a *covered person* with an *illness* or *injury*. DME is only "durable" if it is prescribed by a *health care practitioner* for an *illness* or *injury* and is not useful to a *covered person* without an *illness* or *injury*.

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:

- **A.** A *subscriber's* legal spouse.
- **B.** A *subscriber's child*, under the age of twenty-six (26).
- **C.** A *full-time student returning from military duty*.
- **D.** A *subscriber's child* over age twenty-six (26) if **all** of the following criteria are met:
  - **1.** The *child* is incapable of self-sustaining employment because of intellectual disability or physical handicap.
  - **2.** The *child* is chiefly dependent upon the *subscriber* for support and maintenance.
  - **3.** The *child's* incapacity existed before he/she reached age twenty-six (26).
  - **4.** The *subscriber's family coverage* remains in force under the Policy.
- **E.** A biological *child* of a *subscriber's child* if the *subscriber's child* is under eighteen (18) years old.
- **F.** If shown in the *policyholder's* current application for coverage as being applicable, a *subscriber's domestic partner*.
- **G.** A *child*, under the age of twenty-six (26), for whom the subscriber (or his/her spouse) was the legal guardian prior to the *child* turning eighteen (18) years of age.
- **H.** A subscriber's stepchild or a *child* of the *subscriber's domestic partner* in the event of the biological parent's death.

Eligible Employee: a person who is either:

- **A.** Employed by the *policyholder* on a permanent, full-time basis for the required number of hours per week as shown in the *policyholder* current application for coverage.
- **B.** 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 stabilize or initiate *treatment* in a *medical emergency*. Emergency medical care must be received on an outpatient basis at a *hospital* or alternate facility. *Benefits* include the facility charge, supplies and all professional services required to stabilize your medical condition and/or initiate *treatment*. This includes placement in an observation bed for the purpose of monitoring your medical condition (rather than being admitted to a hospital for an inpatient stay). *Benefits* are not available for services to treat a medical condition that does not meet the definition of a *medical emergency*.

Emergency Room Visit: a meeting between you and a *health care practitioner* that*:*

- **A.** Occurs at the emergency room.
- **B.** Includes only the *charges* for the emergency room fee billed by the *facility* for use of the emergency room.

Exception: *prior authorization* for coverage of a *non-formulary drug* or to bypass a step therapy requirement. Each exception will state the type and extent of the *treatment* or other *health care services* that we have authorized.

Expanded Preventive Drug(s): any drug on our Expanded Preventive Drug List, as determined by us. Expanded preventive drugs may include those *prescription legend drugs* the Internal Revenue Service has indicated are taken to prevent exacerbation of a chronic condition or the development of a secondary condition.

Expedited Grievance: a *grievance* where any of the following conditions applies:

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

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:

- **A.** It is not currently recognized as accepted medical practice.
- **B.** It was not recognized as accepted medical practice at the time the *charges* were incurred.
- **C.** It has not been approved by the United States Food and Drug Administration (FDA) upon completion of Phase III clinical investigation.
- **D.** 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).
- **E.** It has not successfully completed all phases of clinical trials, unless required by law.
- **F.** It is based upon or similar to a treatment protocol used in at least one on-going clinical trial.
- **G.** Prevailing peer-reviewed medical literature in the United States has failed to demonstrate that it is safe and effective for your condition.
- **H.** There is not enough scientific evidence to demonstrate or make a convincing argument that:
  - **1.** It can measure or alter the sought-after changes to your *illness* or *injury.*
  - **2.** 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.
- **I.** 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 made by us to which **all** of the following apply:

- **A.** We have reviewed the proposed *treatment*.
- **B.** Based on the information provided, we have determined the *treatment* is *experimental/ investigational/ unproven*.
- **C.** Based on the information provided, we denied the *treatment* or payment for the *treatment*.

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 section 5. JJ. (Covered Expenses / Prescription Legend Drugs and Supplies). The drugs covered on our formulary may change from time to time.

Formulary Drug(s): Drugs or supplies classified as *preferred generic drugs*, *preferred brand-name drugs*, *preferred specialty drugs, non-preferred generic drugs*, *non-preferred brand-name drugs,* or *non-preferred specialty 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:

- **A.** 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.
- **B.** The *child* was under the age of 27 when called to federal active duty.
- **C.** 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:

- **A.** Attend an accredited school for the number of credits, hours, or courses required by the school to be considered a *full-time student*.
- **B.** Attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools.
- **C.** 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.

Gene or Cell Therapy Center of Excellence: a facility that specializes in developing, researching, and providing these types of innovative treatments.

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

- **A.** Gene expression and determination of gene function (genomics).
- **B.** Analysis of genetic variations.
- **C.** Multiple gene panels.
- **D.** Genetic bio-markers.

E. Biochemical biomarkers.

F. Molecular pathology.

G. Measurements of gene expression and transcription products.

H. Cytogenetic tests.

I. Topographic genotyping.

J. Microarray testing.

K. Whole genome sequencing.

L. 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.

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

Habilitative Services: *health care services* that help a person keep, learn, or improve skills and functioning for *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* as defined in section 5. PP. (Covered Expenses / 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), magnetic resonance venography (MRV), positron emission tomography (PET), single photon emission computed tomography (SPECT), coronary computed tomography angiography (CCTA), 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:

A. The plan is developed by your attending *health care practitioner*.

B. The plan is approved by your attending *health care practitioner* in writing.

C. 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).

D. 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 generally dispenses extended *supplies* of maintenance medications (typically greater than a 30-34-day supply) via the U.S. Postal Service or other package delivery service. This excludes a *retail pharmacy* that offers medication delivery services.

Home Health Aide Services: services performed by a home health aide which:

A. Are not required to be performed by a registered nurse or licensed practical nurse.

B. 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 (6) consecutive months or less.

B. Available on an intermittent basis with on-call *health care services* available on a 24-hour basis.

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:

A. A convalescent or extended care facility unit within or affiliated with the hospital.

B. A clinic.

C. A nursing, rest, or convalescent home.

D. An extended care facility.

E. A facility operated mainly for care of the aged.

F. Sub-acute care center.

G. 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.

Independent Freestanding Emergency Department: a health care facility that:

A. Is geographically separate and distinct and licensed separately from a *hospital* under applicable State law.

B. Provides any of the emergency services as defined in 42 USC 300gg-11(a)(3)(C).

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. Such inability must be documented by a *health care practitioner*.

Infertility or Fertility Treatment: a *health care service* that is intended to:

A. Promote or preserve *fertility*.

B. Achieve and maintain a condition of pregnancy. For purposes of this definition, infertility or fertility treatment includes, but is not limited to:

1. *Fertility* tests and drugs.

2. Tests and exams done to prepare for or follow through with induced conception.

3. Surgical reversal of a sterilized state that was a result of a previous surgery.

4. Sperm enhancement procedures.

5. Direct attempts to cause or maintain pregnancy by any means including but not limited to 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.

Lethal Fetal Anomaly: an anomaly which predictably results in fetal demise either in utero or shortly (within 72 hours) after delivery.

Limited Family Coverage: coverage that applies to:

A. A *subscriber* and his/her eligible spouse or *domestic partner* who is a *covered dependent*.

B. 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 as follows:

A. For covered *health care services* provided by a *preferred provider,* the maximum allowable fee is the rate negotiated between us and the *preferred provider*.

B. As required by state or federal law, for covered:

1. *Emergency medical care* in an emergency department of a *hospital* or in an *independent freestanding emergency department.*

2. Air ambulance services.

3. *Health care services* provided at a *preferred facility* by a *non-preferred provider;* the maximum allowable fee is the *qualifying payment amount.*

However, there is an exception for 3.; if a *covered person* signs a *non-preferred provider's* No Surprises Act notice and consent form, as determined by us, the maximum allowable fee is the *maximum out-of-network allowable fee* for *health care services* provided at a *preferred facility* by a *non-preferred provider*.

C. For covered *health care services* not described in A. or B., above, 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:

A. A description of our specific methodology, including, but not limited to, the following:

1. The source of the data used, such as our claims experience, an expert panel of *health care providers*, or other sources.

2. The frequency of updating such data.

3. The geographic area used.

4. If applicable, the percentile used by us in determining the *maximum allowable fee*.

5. Any supplemental information used by us in determining the *maximum allowable fee*.

B. 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*, other than for:

A. E*mergency medical care* in an emergency department of a *hospital* or in an *independent freestanding emergency department*.

B. Air ambulance services.

C. *Health care services* at a *preferred facility by a non-preferred provider*, as required by state or federal law, unless the *covered person* signs a *non-preferred provider's* No Surprises Act notice and consent form. 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:

A. 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*.

B. Serious impairment to a person's bodily functions.

C. 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:

A. Consistent with and appropriate for the diagnosis or *treatment* of your *illness* or *injury*.

B. 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.

C. Substantiated by the clinical documentation.

D. 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.

E. Proven to be useful or likely to be successful, yield additional information, or improve clinical outcome.

F. 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:

A. Used primarily to treat an *illness* or *injury*.

B. Generally, not useful to a person in the absence of an *illness* or *injury*.

C. The most appropriate item that can be safely provided to you and accomplish the desired end result in the most economical manner.

D. Not primarily for the patient's comfort or convenience.

E. 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:

A. Inpatient hospitalization.

B. Outpatient *health care services* at a *hospital*.

For outpatient *health care services*, miscellaneous hospital expenses include *charges* for:

A. Use of the *hospital's* emergency room.

B. *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:

A. Are associated with distress, dysfunction, or *physical illness*.

B. Represent a dysfunctional response to a situation or event that exposes you to an increased risk of pain, suffering, conflict, *physical illness,* or death. Behavior problems, learning disabilities, or *developmental delays* are not nervous or mental disorders.

Non-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-Formulary Drug(s): any drug that is not included on the *formulary*.

Non-Preferred Brand Drug(s): any *brand-name drug* included on our *formulary* for which member *cost sharing* is higher than for a *preferred brand-name 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 drugs designated as non-preferred brand drugs on our *formulary* may change from time to time.

Non-Preferred Generic Drug(s): any non-preferred generic drug included on our *formulary* for which member *cost sharing* is higher than for a *preferred generic drug*. For purposes of the Policy, we may classify a non-preferred generic drug as a *brand-name drug* if we determine that its price is comparable to the price of the equivalent *brand-name drug*. The drugs designated as non-preferred generic drugs on our *formulary* may change from time to time.

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.

Non-Preferred Specialty Drug(s): any *specialty drug* included on our formulary for which member *cost sharing* is higher than for a *preferred specialty drug*. The drugs designated as non-preferred specialty drugs on our *formulary* may change from time to time.

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: 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*, an 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; or occurs via telephone or interactive audio-video telecommunication.

B. Includes you receiving medical and/or behavioral health evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology or as determined by us).

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.

Orthotics: Custom-made rigid or semi-rigid supportive devices used to:

A. Support, align, prevent, or correct deformities.

B. Improve the function of movable parts of the body.

C. Limit or stop motion of a weak or diseased body part.

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. In determining whether you've reached your out-of-pocket limit, amounts such as these will not count towards your out-of-pocket limit:

A. Amounts you pay for non-covered *health care services*.

B. Amounts you pay that exceed the *maximum allowable fee*.

C. Amounts you pay for the difference between the *brand-name drug* and the lower cost equivalent drug (*generic drug* or *biosimilar)*.

D. Any *coinsurance* you pay for a SaveOnSP *specialty drug*.

E. Amounts applied through use of a coupon, *copayment* assistance program or rebate for payment of a SaveOnSP *specialty drug*.

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:

A. 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.).

B. 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.

C. Practices medicine within the lawful scope of his/her license.

Placed for Adoption / Placement for Adoption: any of the following:

A. 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*.

B. 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.

C. 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(2)(w), places a *child* in the *subscriber's* home under § 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.

D. 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.

E. 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*.

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.

Preferred Brand-Name Drug(s): any *brand-name drug* named on our formulary for which member *cost sharing* is lower than for a non-preferred brand-name 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 drugs designated as preferred brand-name drugs on our *formulary* may change from time to time. Please see https://wpshealth.com/resources/files/32053_preferred-drug-guide.pdf.

Preferred Facility: a *hospital* or ambulatory surgery center that has entered into a written agreement with us to provide covered services to you as of the date upon which the services are provided. A *hospital's* or ambulatory surgery center's participation status may change from time to time. Please refer to our on-line directory or contact us for a listing of preferred facilities.

Preferred Generic Drug(s): any *generic drug* named on our formulary for which member *cost sharing* is lower than for a non-preferred *generic drug*. 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 drugs designated as preferred generic drugs on our *formulary* may change from time to time. Please see https://wpshealth.com/resources/files/32053_preferred-drug-guide.pdf.

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*.

Preferred Specialty Drug(s): any *specialty drug* named on our *formulary* for which member *cost sharing* is lower than for a *non-preferred specialty drug.* This may include *biosimilar* drugs. The drugs designated as preferred specialty drugs on our *formulary* may change from time to time. Please see https://wpshealth.com/resources/files/32053_preferred-drug-guide.pdf.

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.

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

A. Evaluate or assess health and well-being.

B. Screen for possible detection of unrevealed illness.

C. Improve health.

D. Extend life expectancy.

Preventive Drug(s): drugs that we are currently required by law to define as preventive drugs include:

A. Aspirin for the prevention of cardiovascular disease (age 50-59) and after twelve (12) weeks of gestation in women who are at high risk for preeclampsia.

B. Fluoride supplements if you are older than six (6) months but younger than seventeen (17) years old.

C. Folic acid for women planning or capable of pregnancy.

D. Oral contraceptives, contraceptive patches, contraceptive devices (e.g., diaphragms, sponges, gel) and contraceptive vaginal rings for birth control.

E. Nicotine replacements (e.g., patches and gum) and covered drugs used for smoking cessation if you are age eighteen (18) and over.

F. Risk reducing medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects.

G. Immunizations.

H. 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%.

I. Bowel preparations related to a preventive colonoscopy.

J. Preexposure prophylaxis (PrEP) antiretroviral therapy for *covered persons* at high risk of HIV acquisition. The USPSTF may change the definition of preventive drugs during the course of the year.

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 and 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 conditions and which meets any of the criteria in the bulleted list below.

A. 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:

1. National Institutes of Health (NIH), including the National Cancer Institute (NCI).

2. Centers for Disease Control and Prevention (CDC).

3. Agency for Healthcare Research and Quality (AHRQ).

4. Centers for Medicare and Medicaid Services (CMS).

5. A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).

6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

7. 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:

a. Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.

b. Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

C. 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 that would be covered under the Policy if it were not *experimental/investigational/unproven*.

Qualifying Payment Amount: the amount of reimbursement allowed for a covered *health care service* provided by a *health care practitioner* who is a *non-participating provider* for *emergency medical care,* air ambulance*,* or *health care services* provided while the *covered person* is receiving treatment at a *participating provider* facility. This amount will be determined in compliance with 42 U.S.C. 300gg et.seq.

Reconstructive Surgery: surgery performed on abnormal structures of the body caused by:

A. Congenital defects.

B. Development abnormalities.

C. Trauma.

D. Infection.

E. Tumors.

F. 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 made by us 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.

Retail Pharmacy: an independent pharmacy, a chain pharmacy, a supermarket pharmacy, a mass merchandiser pharmacy, or an outpatient pharmacy that is licensed as a pharmacy by the state in which it is located and that dispenses medications to the general public at retail prices. Such term does not include a *home delivery pharmacy* that dispenses prescription medications to patients primarily via the U.S. Postal Service or other package delivery service.

Routine Patient Care Costs:

A. Include costs associated with any of the following:

1. *Health care services* that are typically covered under the Policy absent a clinical trial.

2. 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.

3. Reasonable and necessary *health care services* used to diagnose and treat complications arising from your participation in a *qualifying clinical trial*.

4. Covered *health care services* needed for reasonable and necessary care arising from the provision of a trial *health care service*.

B. Do not include costs associated with any of the following:

1. *Experimental/investigational/unproven health care services* with the exception of:

a. *Category B devices*.

b. Certain promising interventions for patients with terminal *illnesses*.

c. Other *health care services* that meet specified criteria in accordance with our medical policy guidelines.

2. *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.

3. *Health care services* provided by the research sponsors at no *charge* to any person enrolled in the trial.

4. *Health care services* that are clearly inconsistent with widely accepted and established *standards* of care for a particular diagnosis.

C. With respect to cancer or other life-threatening diseases or 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 disease or condition and which meets any of the following criteria listed 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). (Includes 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.

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.

4. The clinical trial must 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.

5. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a *covered expense* and is not otherwise excluded under the Policy.

Single Coverage: coverage that applies only to a *subscriber*.

Skilled Nursing Care: *health care services* that:

A. Are furnished pursuant to a *health care practitioner's* orders.

B. Require the skills of professional personnel such as a registered nurse or a licensed practical nurse.

C. 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:

A. Is operating pursuant to state and federal law.

B. Is under the full-time supervision of a *health care practitioner* or registered nurse.

C. Provides services seven days a week, 24 hours a day, including *skilled nursing care* and therapies for the recovery of health or physical strength.

D. Is not a place primarily for *custodial care* or *maintenance care*.

E. Requires compensation from its patients.

F. Admits patients only upon a *health care practitioner's* orders.

G. Has an agreement to have a *health care practitioner's* services available when needed.

H. Maintains adequate records for all patients.

I. Has a written transfer agreement with at least one *hospital*.

Specialty Care Practitioner: a 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 Drug(s): *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.

C. Generally high cost.

To determine if a drug is a *specialty drug* or a SaveOnSP *specialty drug* and if that drug requires our *prior authorization*, visit https://www.wpshealth.com/resources/files/drugpreauth.pdf and https://www.wpshealth.com/resources/files/35619_wps-esi-saveonsp-specialty-drug-list.pdf or call the telephone number shown on your identification card.

Specialty Drug Deductible: the specified amount you are required to pay for a covered *specialty drug* dispensed by a *specialty pharmacy* in a *calendar year* before *benefits* are payable under the Policy. Your specialty drug deductible amount (if applicable) is shown in your Schedule of Benefits.

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: a *covered employee.*

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:

A. An operative procedure performed by a *health care practitioner* that we recognize as *treatment* of an *illness* or *injury.*

B. 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, interactive audio and video conferencing.

Therapy Visit: a meeting between you and a *health care practitioner,* excluding a chiropractor or a massage therapist, that:

A. 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.

B. Involves you receiving physical, speech, or occupational therapy.

Totally Disabled / 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 o*utpatient 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.

Transplant Access Program: a *designated transplant facility* that does not qualify as a *Center of Excellence* but is included in the transplant network to improve accessibility when a *Center of Excellence* is unavailable as determined by us.

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):

A. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function.

B. 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 resolve your problem by taking the steps outlined in sections 11. (Claim Filing and Processing Procedures), 12. (Internal Grievance and Appeals Procedures), and 13. (Independent External Review).

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 800-236-8517 outside of Madison or 608-266-0103 in Madison and request a complaint form.