Certificate of Coverage
Preferred Provider Plan

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

WARNING: 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* in non-emergency situations, 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 policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar health care services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE *COINSURANCE, DEDUCTIBLE* AND *COPAYMENT* AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. *Non-preferred providers* may bill you for any amount up to the billed *charge* after we have paid our portion of the bill. *Preferred providers* have agreed to accept discounted payment for covered *health care services* with no additional billing to you other than *copayment, coinsurance* and *deductible* amounts. You may obtain further information about the preferred status of *health care providers* and information on out-of-pocket expenses by calling the Customer Service toll-free telephone number on your identification card or visiting our website at wpshealth.com. This Certificate of Coverage (the "Certificate") includes a Schedule of Benefits. It may also include one or several endorsements. **Please read all of these documents carefully so you know and understand your coverage.**

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

You are responsible for choosing your *preferred provider* from our most recent Preferred Provider Directory. The *preferred providers* and all other health care providers are independent contractors and are not employed by WPS. WPS merely provides benefits for covered expenses in accordance with the group policy. WPS does not provide *health care services.* WPS does not warrant or guarantee in any way 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. (Your Relationship with your Physician, Hospital or Other Health Care Provider). Optometric services may be provided by a *physician* licensed to practice medicine in all its branches or an optometrist licensed in the state of Illinois.

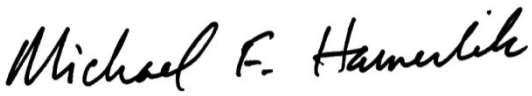
The amount we pay for a covered *health care service* will always be limited to the *maximum allowable fee*, as defined in Section 12. (Definitions). This amount may be less than the amount billed and in certain cases, you will be responsible for paying the difference. If you would like more information, please contact our Customer Service Department by calling the telephone number shown on your WPS identification card.

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

In performing its obligations under the Policy, WPS is acting only as a health insurer with respect to the Policy. We are not in any way acting as a *plan* administrator, a *plan* sponsor or a *plan* trustee for purposes of the Employee Retirement Income Security Act of 1974 (ERISA) as amended or any other law.

The Policy is issued by WPS and delivered to the *policyholder* in Illinois. 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 Illinois. All *benefits* are provided in accordance with the terms, conditions, and provisions of the Policy, any endorsements attached to this Certificate, your completed application for this insurance, and applicable laws and regulations.

Wisconsin Physicians Service Insurance Corporation



Michael F. Hamerlik
President and Chief Executive Officer

Table of Contents

1. GENERAL INFORMATION

A. General Description of Coverage

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

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

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

B. Entire Contract

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

C. How to Use This Certificate

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

Each italicized term used in this Certificate has a special meaning, which is explained in Section 12. (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 *plan 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 12. (Definitions) for more information.

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

Non-preferred providers are *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 12. (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. We also have the sole and exclusive right to pay *benefits* for a particular *health care service*.

In certain circumstances for purposes of overall cost savings or efficiency, we may pay *benefits* for *health care services:* (1) at the *preferred provider* level of benefits for a *health care service* provided by a *non-preferred provider*; or (2) that are not covered under the Policy, to the limited extent provided in Section 5. B. (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 may 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 may also authorize other persons or entities to exercise discretionary authority with regard to the Policy without notice to you. By accepting this Certificate, you agree to cooperate fully with those persons or entities in the performance of their responsibilities.

2. ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE

A. Employee Eligibility

An individual who meets the definition of *eligible employee* is eligible for coverage under the Policy immediately 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. (When Coverage Ends) for more details.

B. Dependent Eligibility

Any family members that meet the definition of *eligible dependent* will become eligible for coverage under the Policy when the *eligible employee* becomes eligible for coverage. *Subscribers* may also enroll new *eligible dependents* who join their family because of birth, legal adoption, *placement for adoption*, marriage, legal guardianship, or court or administrative order. See Section 2. F. (Special Enrollment Periods) for more information about these special enrollment opportunities. Once a *subscriber* enrolls his/her first *eligible dependent*, his/her *single coverage* will switch to *family coverage.*

C. How to Enroll

In order to obtain coverage under the Policy, an *eligible dependent* or *eligible employee* must complete and submit the enrollment form provided by the *policyholder* to us **within 31 days** after becoming eligible. If an *eligible employee* or *eligible dependent* does not enroll for coverage within this period and he/she is not otherwise eligible for a special enrollment period, as outlined below, he/she must wait to enroll for coverage during the next annual open enrollment period.

D. 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 enrollment form and any required premium **within 31 days** after the employee and any dependents become eligible to enroll.

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.

E. Annual Open 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 open 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 open enrollment period.

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

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

F. 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 open enrollment period. These circumstances are explained in Paragraphs 1 – 7 below.

Except as noted below, we generally must receive an enrollment form 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 we do not receive the enrollment form within this time period, you may have to wait until the next annual open enrollment period to add or change your 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*.

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 Children's Health Insurance Program (CHIP), the *eligible employee* or *eligible dependent* may enroll in the Policy by submitting an enrollment form **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 enrollment form within 31 days of his/her initial date of eligibility and waived coverage for himself/herself and/or his/her *eligible dependents* because the *eligible employee* and/or *eligible dependents* had other health care coverage;

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

c. The *eligible employee* and/or *eligible dependents* lost the other health care coverage that they had when they waived the *benefits* of the Policy because of any of the following:

1) Loss of eligibility;

2) Contributions made on your behalf towards your other health care coverage ended;

3) COBRA continuation coverage ended;

4) The *eligible employee* and/or *eligible dependent* no longer lives or works in the *plan*'s *geographical service area* and no other *benefit* option is available;

5) The *plan* no longer offers *benefits* to a class of individuals that includes the *eligible employee* and/or *eligible dependent*;

6) The *eligible employee* and/or *eligible dependent* incurs a claim that would exceed a lifetime limit on all *benefits;* or

7) The *eligible employee* and/or *eligible dependent* loses eligibility for Medicaid, including the Children's Health Insurance Program (CHIP).

If health care coverage is lost for one of the reasons outlined in Paragraph 2. c. 1) –6) above, coverage for the *eligible employee* and/or his/her *eligible dependents* under the Policy will begin on the first day following the date the *eligible employee*'s other health coverage ended if we receive an enrollment form **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 enrollment form **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 open enrollment period.

3. Marriage

If a *subscriber* acquires an *eligible dependent* through marriage or *civil union*, he/she may enroll the *eligible dependent spouse*. If we receive an enrollment form **within 31 days** after the date of marriage or *civil union*, the eligible *spouse*'s coverage will be effective on the first day of the calendar month following date of marriage or civil union. Otherwise, the *spouse* may not be added until the next annual open enrollment period.

If the *subscriber* previously had *single coverage*, enrolling a *spouse* will switch him/her to *family coverage.*

4. Birth of a Child

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 us of the *child's* birth.

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 31 days of that *child's* life immediately following that *child's* date of birth.

To add a newborn natural *child*, you must submit an application for coverage form and pay any required premium within 31 days after the date of birth. If you fail to notify us and do not make any required payment beyond the 31-day period, coverage will end. If we do not receive the enrollment form within 31 days after the *child's* birth, the newborn may not be added until the next annual open enrollment period.

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

If a *subscriber* has *family coverage*, coverage is provided for the adopted *child* who meets the definition of *eligible dependent* from the moment of that *child's* date of adoption or *placement for adoption*. You must notify us of the *child's* adoption or *placement for adoption*.

If a *subscriber* has *single coverage* and wishes to change to *family coverage* because of his/her adoption of a *child* or a *child* placed *for adoption*, we must receive an enrollment form listing the *child(ren)* the *subscriber* wants to enroll within 31 days after the date of the adoption or *placement for adoption*. The effective date for such *family coverage*

will be one of the following: (a) the date a court makes a final order granting adoption of the *child* by the *subscriber*; (b) the date that the *child* is *placed for adoption* with the *subscriber*; whichever occurs first. If we receive the enrollment form after the 31-day enrollment period ends, the *child(ren)* 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. Court Order

To the extent required by Section 750 ILCS 5/505.2, Illinois Statutes, as amended, if a court orders a *subscriber* with single or family coverage to provide coverage for health care expenses for his/her *dependent child*, that *subscriber* will be issued *family coverage* to include that *child* effective as of the date that court order is issued unless another coverage date is contained in that order, provided that child is eligible as a dependent for coverage under the policy. Written application for that child's coverage must be made by either the *subscriber*, the *child*'s other parent, or the Illinois Department of Healthcare and Family Services using our application form. A copy of the court order and the appropriate premium for his/her coverage must also be submitted.

The effective date of *family coverage* under this section will be either: (1) the date that court order is issued; or (2) another coverage date contained in that court order. As long as the *subscriber* is eligible for *family coverage* under the policy, that *child's* coverage will continue under the Policy until we have received satisfactory written evidence that the court order is no longer in effect or the child has coverage under another group policy or individual policy that provides comparable health care coverage, as applicable, unless that *child*'s coverage ends sooner in accordance with Section 8. (When Coverage Ends). The *subscriber* must notify us in writing as soon as reasonably possible after he/she becomes aware that the applicable court order is expiring and/or that other coverage is becoming effective for his/her *dependent child*.

7. Adding a Domestic Partner

This paragraph 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 eligible dependent 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" form.

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

3. OBTAINING SERVICES

A. Preferred Provider Benefits

Preferred provider benefits are payable only when *health care services* are received from:

1. A *preferred provider***;** or

2. A non-*preferred provider* with an approved *prior authorization* to seek health care services from that provider. We will only approve *health care services* provided by a *non-preferred provider* when those *health care services* for diagnosis and management of your illness or injury are not available from a *preferred provider.* You will not incur any greater costs than if the covered service had been provided by a *preferred provider.*

3. A radiologist, pathologist, or anesthesiologist who is on staff at a preferred hospital, or performed at a preferred hospital, or with an approved prior authorization to a non-preferred hospital.

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

Please note that if a *preferred provider* finds it *medically necessary* to refer you to a *non-preferred provider*, we shall ensure that you shall incur no greater out-of-pocket expenses than had you received services from a *preferred provider*. This exception does not apply if you willfully choose to access a non-preferred provider for health care services available through a *preferred provider*. Before visiting a *non-preferred provider*, you must follow the prior authorization process outlined above and obtain our approval. Otherwise, standard benefits for *non-preferred providers* will apply.

B. Non-Preferred Provider Benefits

If you receive *health care services* from a *non-preferred provider*, *benefits* provided are limited to the *maximum out-of-network allowable fee* and you will be responsible for paying any difference between that amount and the *charge* billed. For example, if the *non-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 *copayment*, *deductible* or *coinsurance* amounts.

If you receive covered radiology, pathology, anesthesia or emergency room physician services from a *non-preferred provider* in a preferred facility, you will not incur any greater costs than if the covered service had been provided by a *preferred provider.*

C. 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).

D. Our Utilization Management Program

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

E. Continuity of Care

1. Provider Termination

To the limited extent required by 215 ILCS 124/20 (a), we will provide *benefits* at the *preferred provider* level for any ongoing *health care services* received from any *health care provider* if we represented during the most recent open enrollment period that the provider was or would be a *preferred provider* who terminates their *preferred provider* status with us for either: (a) 90 days from the date of our notice to the *covered person* that their *preferred provider* is terminating their *preferred provider* status; or (b) for a *covered person* who is in the third trimester of pregnancy until the completion of postpartum care for the *covered person* and the infant. This provision does not apply when: (a) the provider no longer practices within the area in which we are authorized to do business; or (b) the provider's participation with us is terminated because of his/her misconduct.

2. New Covered Person

To the limited extent required by 215 ILCS 124/20 (b), we will provide *benefits* at the *preferred provider* level for any ongoing *health care services* received from your current *health care provider* who is a *non-preferred provider* if you are a newly enrolled *subscriber* or newly enrolled *covered dependent* with us for either: (a) 90 days from the effective date of enrollment if the *covered person* continues an ongoing course of treatment; or (b) for a *covered person* who is in the third trimester of pregnancy on the effective date of enrollment, until the completion of postpartum care for the *covered person* and the infant. This provision does not apply when: (a) the *covered person* has successfully

transitioned to a *preferred provider*; or (b) the covered person has already met or exceeded the benefit limitations of the plan; or (3) the care being provided is not medically necessary.

This subsection 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 215 ILCS 124/20. 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.

F. Prior Authorization

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

2. **When Do I Have to Obtain Prior Authorization?** You are required to obtain *prior authorization* before you visit certain *health care providers* or receive certain *health care services*, such as planned inpatient admissions, pain management, spinal surgery, new technologies (which may be considered *experimental/investigational/unproven*), non-emergency ambulance, high-cost *durable medical equipment*, *high-technology imaging*, or procedures that could potentially be considered *cosmetic treatment*. Below is a list of *providers* and *health care services* for which *prior authorization* is required. More detailed information is located on our website at wpshealth.com/prior-auth

   a. Alternative Communications Device/Speech Generating Device or Digitized Speech;

   b. Bone Anchored Hearing Aids (BAHA);

   c. Bariatric Surgical Services;

   d. Biofeedback;

   e. Behavioral Health Services: Inpatient and residential;

   f. Bone Growth (Osteogenesis) Stimulators (BGS);

   g. Botulinum Toxin Injections;

   h. CPAP/BiPAP Machines;

   i. Clinical Trials;

   j. Cochlear Implants;

   k. Cosmetic and Plastic Surgery Procedures (and any procedure that may be considered cosmetic);

   Examples of potential cosmetic procedures:
   - Blepharoplasty, canthoplasty, eyelid, or eyebrow surgery;
   - Panniculectomy;
   - Pectus excavatum/carinatum;
   - Port Wine Stain Laser Treatment;
   - Reduction/augmentation mammoplasty/mastopexy and related services (Services related to breast reconstruction following mastectomy do not require prior authorization);
   - Rhinoplasty;
   - Temporomandibular Joint Disease (TMJ);
   - Orthognathic surgical services;
   - Varicose vein treatment; and
   - Laser treatment for psoriasis.

   l. Cranial Orthotic;

   m. Deep Brain Stimulation (DBS);

n. Durable Medical Equipment (DME):

- rental above $750 per month or purchase above $1,000 threshold;
- All CPAP/BiPAP rentals and purchases require authorization;
- Alternative Communications and Speech generating devices;
- Crutch substitutes;
- Hospital beds;
- Power wheelchairs, custom built wheelchairs, and scooters;
- Home UVB light treatment of skin conditions; and
- Wearable cardiac defibrillator vest.

o. Genetic Testing;

p. High-tech Radiology: MRA, MRS, PET Scan;

q. Home Infusion Services;

r. Hyperbaric Oxygen Therapy (when non-emergency use such as diabetic wound care;

s. Intensity Modulated Radiation Therapy (IMRT);

t. Immune Globulin (IVIG);

u. Inpatient Admission: Planned (elective/scheduled) Includes Skilled Nursing Facility (SNF), Long-term Acute Care (LTAC) facility, and Inpatient Hospice Facility;

v. Intraoperative Neurophysiological Monitoring Neuropsychological Testing;

w. Neuropsychological Testing;

x. Neurostimulation;

y. New technology: medical, surgical, or biomedical services that might be considered experimental, investigational, or unproven;

z. Pain Management Procedures:

- Epidural steroid injections;
- Facet joint injections (Includes facet, MBB, zygapophysial joint, paravertebral facet joint, and dorsal/posterior ramus injections);
- Intrathecal pump implantation;
- Lumbar discography;
- Radiofrequency ablation;
- Spinal cord/dorsal column Stimulation;
- Automated percutaneous lumbar discectomy; and
- Sacro-Iliac (SI) joint injections and treatment.

aa. Pediatric Vision, and Orthoptic/Pleoptic Training;

bb. Physical, Occupational, and Speech Therapy (after the initial visit);

cc. Prosthetics greater than $5,000;

dd. Proton Beam Radiotherapy;

ee. Skilled Nursing Facility;

ff. Sleep Study Evaluation and Treatment of Sleep Disorder:

- Polysomnograms (sleep study: Home and in-lab);
- CPAP/BiPAP machines;
- Oral appliances; and

- Surgical Procedures (UPPP).

gg. Spinal Surgery;

hh. Stereotactic Radiosurgery/Radiotherapy;

ii. Therapeutic Contact Lens;

jj. Total Ankle Arthroplasty;

kk. Total Shoulder Arthroplasty;

ll. Transplants;

mm. Transportation of Patients: Non-Emergency (MediVan, ground, or air ambulance); and

nn. *Prescription Legend Drugs.*

3. **How do I Request Prior Authorization?**

   a. *Health care Services* Other Than *prescription legend drugs*: Ask your *health care practitioner* to contact our Customer Service Department by calling the telephone number shown on your identification card or to download, complete, and submit the printable Prior Authorization Form on our website. You should then call Customer Service to verify that we have received the *prior authorization* request. Please note that for genetic services, we will only accept *prior authorization* requests from the ordering *health care provider* (e.g. your *physician*); we will not accept *prior authorization* requests from the laboratory that will perform the genetic services.

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

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

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

6. **My Prior Authorization Request Was Approved – Now What?** If we or our *delegate* approve your request, our *prior authorization* will only be valid for: (a) the *covered person* for whom the *prior authorization* was made; (b) the *health care services* specified in the *prior authorization* and approved by us; and (c) the specific period of time and service location approved by us.

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

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

8. **What Happens If I Do Not Obtain a Prior Authorization?** Failure to comply with our *prior authorization* requirements may result in an initial denial if medical records are not included. If, however, a *health care service* is denied solely because you did not obtain our *prior authorization*, or records were not included, you can request that we review and reconsider the denial of *benefits* by following the procedures outlined in Section 11. (Claim Filing and Processing Procedures). If you prove to us 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 to obtain emergency care or urgent care at an emergency or urgent care facility

4. PAYMENT OF BENEFITS

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

A. Deductible

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

After you satisfy your *deductible*, most *charges* for *covered expenses* will still be subject to any applicable *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* annual *deductible* amount shown in the Schedule of Benefits.

B. Coinsurance

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

C. Copayments

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

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

D. Out-of-Pocket Limits

Your *out-of-pocket limits* are shown in the Schedule of Benefits.

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

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

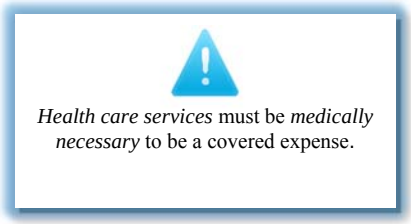
E. Maximum Allowable Fee

We'll pay *charges* for the *covered expenses* described in Section 5. (Covered Expenses) up to the *maximum allowable fee*. If you see a *non-preferred provider*, you are solely responsible for paying any *charge* that exceeds the *maximum out-of-*

network allowable fee. Regardless of what *health care provider* you see, you are also solely responsible for paying any *charge* for a *health care service* that we do not cover under the Policy.

You may contact us before receiving a *health care service,* so you will know if the *health care provider's* estimated *charge* is less than or equal to the *maximum allowable fee*. In order for us to provide you with this information, you will need to give us with the following information: (1) the estimated amount that your *health care provider* will bill for the *health care service*; (2) the procedure code, if applicable; (3) the name of the *health care provider* providing the service; and (4) the facility where the service will be provided.

5. COVERED EXPENSES



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

Please note that any of the *health care services* listed below may require our *prior authorization*. Please see Section 3. 1. (Obtaining Services / Prior Authorization) for detailed information about our *prior authorizations*. Additionally, all *benefits* are subject to the *deductible* and *coinsurance* amounts, *copayment* amounts, *out-of-pocket limits* and all other provisions stated in the Schedule of Benefits. See Section 4. (Payment of *Benefits*) for an explanation of these cost-sharing structures.

A. Allergy Testing and *Treatment*

Therapy and testing for *treatment* of allergies.

B. 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 may consider paying for such non-covered *health care services.* and we may consider an alternative care plan if we find that:

1. The recommended alternative care offers a medical therapeutic value equal to or greater than the current *treatment* or *confinement*;
2. The current *treatment* or *confinement* is covered under the Policy;
3. The current *treatment* or *confinement* may be changed without jeopardizing your health; and
4. The *health care services* provided under the alternative care plan will be as cost effective as the *health care services* provided under the current *treatment* or *confinement* plan.

C. Ambulance Services

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

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

3. Emergency ambulance transports must be made to the closest local facility or *preferred provider* that can provide *health care services* appropriate for your *illness* or *injury*. If none of these facilities are located in your local area, you are covered for transports to the closest facility outside your local area.

4. Benefits are not payable for ambulance services:

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

   b. When *ambulance services* are used solely for the personal convenience or preference of you, a family member, *health care practitioner*, or other health care provider; or

   c. When *ambulance services* are provided by anyone other than a licensed *ambulance service*.

D. Anesthesia Services

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

E. Autism Services

Benefits are payable for *charges* for *covered expenses* as described in subsection 2. (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*.

1. **Definitions:** The following definitions apply to this Section 5. D. only:

   a. **Autism Spectrum Disorder(s):** pervasive development disorder(s) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

   b. **Diagnosis of Autism Spectrum Disorder(s):** one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed or ordered by: (a) a *health care practitioner* licensed to practice medicine in all its branches; or with expertise in diagnosing autism spectrum disorders.

   c. **Medically Necessary:** any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following: (a) prevent the onset of an illness, condition, injury, disease or disability; (b) reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or (c) assist to achieve or maintain maximum functional activity in performing daily activities.

   d. **Treatment for/of Autism Spectrum Disorder(s):** such treatment shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by:

      1) a *health care practitioner* licensed to practice medicine in all its branches; or

      2) a certified, registered, or licensed health care professional with expertise in treating effects of *autism spectrum disorders* when the care is *medically necessary* and ordered by a *health care practitioner* licensed to practice medicine in all its branches:

         a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.

b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

3) As used in this paragraph d., "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (a) self-care and feeding, (b) pragmatic, receptive, and expressive language, (c) cognitive functioning, (d) applied behavior analysis, intervention, and modification, (e) motor planning, and (f) sensory processing.

2. Covered Autism Services:

Charges for the *diagnosis of autism spectrum disorders* and for the *treatment of autism spectrum disorders* for *covered persons* under 21 years of age to the extent that the diagnosis and *treatment of autism spectrum disorders* are not already covered by the policy. *Treatment of autism spectrum disorders* will not be subject to any limits on the number of visits.

Upon our request, a provider of *treatment for autism spectrum disorders* shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is *medically necessary* and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

When making a determination of medical necessity for a treatment modality for *autism spectrum disorders*, we will make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a *health care practitioner* with expertise in the most current and effective treatment modalities for *autism spectrum disorders*.

Coverage for medically necessary early intervention services must be delivered by certified early intervention specialists, as defined in 89 Ill Admin. Code 500 and any subsequent amendments thereto.

F. Behavioral Health Services

Inpatient, residential, and transitional services may require *prior authorization*.
See wpshealth.com

1. Definitions. The following definitions apply to this Section 5. F. only:

a. Acute Treatment Services: 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

b. Behavioral Health Practitioner: a *health care practitioner* who is duly licensed to provide *health care services* for *mental illness disorders*, *serious mental illness* or *substance use disorders*.

c. Clinical Stabilization Services: 24-hour treatment, usually following *acute treatment services* for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

d. Substance Use Disorder Rehabilitation Treatment: an organized, intensive, structured, rehabilitative treatment program of either a *hospital* or *substance use disorder treatment facility*. It does not include programs consisting primarily of counseling by individuals (other than a *behavioral health practitioner*), court ordered evaluations,

programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

e. **Substance Use Disorder Treatment Facility:** a facility (other than a hospital) whose primary function is the treatment of *substance use disorder*s and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

2. **Covered Behavioral Health Services:**

a. **Substance Use Disorder Rehabilitation Treatment.** Benefits for all of the covered services described in the Policy are available for *substance use disorder* rehabilitation *treatment* including *medically necessary acute treatment services and medically necessary clinical stabilization services*. In addition, benefits will be provided if these covered services are provided by a *behavioral health practitioner* in a *substance use disorder treatment facility*. All medical necessity determinations for *substance use disorder*s will be made in accordance with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria.

b. **Mental Illness Disorder and Substance Use Disorder Services.** Benefits for all of the covered services described in the Policy are available for the diagnosis and/or *treatment* of a *mental illness disorder* and/or a *substance use disorder*. Medical care for the *treatment* of a *mental illness disorder* or a *substance use disorder* is eligible when provided by a behavioral health practitioner working within the scope of their license.

G. Blood and Blood Plasma

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

H. Breast Cancer Pain Medication and Therapy

1. **Definition of Pain Therapy:** therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

2. **Covered Pain Medication and Therapy:** Pain medication and pain therapy related to the *treatment* of breast cancer.

I. Breast Implant Removal

Removal of breast implants when the removal of the implant is *medically necessary treatment* for an *illness* or *injury*. This subsection does not apply to surgery performed for removal of breast implants that were implanted solely for cosmetic reasons. Cosmetic reasons do not include cosmetic surgery performed as reconstruction resulting from illness or injury.

J. 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 while you are an outpatient receiving services in a facility with a facility-approved cardiac rehabilitation program.

2. **Cardiac Rehabilitation Exclusions:**

The Policy provides no *benefits* for 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.

K. Chiropractic and Osteopathic Manipulations

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

1. **Covered Chiropractic Services**: Manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.

2. **Chiropractic Services Limitation:**

   Chiropractic and osteopathic manipulations will be limited to a maximum of 25 visits per *covered person* per *calendar year*.

3. **Chiropractic Services Exclusion:**

   The Policy provides no *benefits* 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).

L. Clinical Trials

1. **Definitions.** The following definitions apply to this Section 5. L. only**:**

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

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

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

   2) Used according to the clinical trial's approved protocols.

   3) Must fall under a covered benefit category and must not be excluded by law, regulation or current Medicare coverage guidelines.

   4) Must be *medically necessary* for the *covered person*, and the amount, duration and frequency of use or application of the service is medically appropriate.

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

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

   c. **Qualifying Clinical Trial:** 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 criteria in the bulleted list below.

      1) Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

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

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

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

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

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

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

g) The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

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

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

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

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

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

d. Routine Patient Care Costs:

1) Include costs associated with any of the following

a) *Health care services* that are typically covered under the Policy absent a clinical trial;

b) Covered *health care services* required solely for the provision of the trial *health care service* and clinically appropriate monitoring of the effects of the *health care service* trial;

c) Reasonable and necessary *health care services* used to diagnose and treat complications arising from your participation in a *qualifying clinical trial*; or

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

2) Do <u>not</u> include costs associated with any of the following:

a) *Experimental/investigational/unproven health care services* with the exception of:

i. *Category B devices*;

ii. Certain promising interventions for patients with terminal *illnesses*; and

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

b) *Health care services* provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

c) *Health care services* provided by the research sponsors at no *charge* to any person enrolled in the trial; or

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

2. **Benefits.**

   Routine patient care costs that you incur while participating in a *qualifying clinical trial* for the *treatment* of cancer or a *life-threatening disease or condition*, for which a clinical trial meets the *qualifying clinical trial* criteria. *Benefits* are available only when you are eligible to participate in an approved clinical trial according to trial protocol.

M. Colorectal Cancer Screening and Diagnosis

Routine colorectal cancer screenings are covered as preventive screenings under Section 5. QQ. (Preventive Care Services). Diagnostic colorectal cancer tests are covered under Sections 5. Q. Diagnostic Services and 5. WW. (Surgical Services).

N. Contraceptives for Birth Control

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

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

Please note that oral contraceptives, contraceptive patches, diaphragms and contraceptive vaginal rings are covered under Section 5. PP. (Prescription Legend Drugs and Supplies).

O. Dental Services

1. **Definition of natural teeth**: teeth that: (1) are naturally developed by normal growth means; (2) are not created within a lab or other setting; (3) have not been extensively restored by amalgam, composite or resin, or do not have an inlay or onlay extending through mesial and distal contacts; (4) do not contain extensive decay or is periodontally involved; and (5) are not more susceptible to *injury* than whole organic teeth.
2. **Covered Dental Services:**
   - **a.** Dental repair or replacement of your *sound natural teeth* due to an *injury* if *treatment* begins within six months of the *injury.* Benefits for treatment of an injury are limited to the following:
     - **1)** Emergency examination;
     - **2)** Necessary diagnostic X-rays;
     - **3)** Endodontic (root canal treatment);
     - **4)** Temporary splinting of teeth:
     - **5)** Prefabricated post and core;
     - **6)** Simple minimal restorative procedures (fillings);
     - **7)** Extractions;
     - **8)** Post-traumatic crowns if such are the only clinically acceptable treatment; and
     - **9)** Replacement of lost teeth due to the injury by implant, dentures or bridges.

b. Extraction of teeth to either prepare the jaw for radiation treatment of neoplastic disease or in preparation for a covered transplant;

c. Sealants on existing teeth to prepare the jaw for chemotherapy treatment of neoplastic disease;

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

1) You are a *child* age six or under; or

2) You have a chronic disability that meets all of the following: a) is attributable to a mental or physical impairment or combination of mental and physical impairments; b) is likely to continue indefinitely; and c) results in substantial limitations in one or more of the following areas: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or

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

e. *Charges* incurred, and anesthetics provided by a dentist in a dentist office, oral surgeon's office, hospital or ambulatory surgical treatment center if you are under the age of 19 and have been diagnosed with an *autism spectrum disorder* or a *developmental disability*.

3. Dental Services Exclusions:

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

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

b. Dental implants or other implant-related procedures, except as specifically stated in paragraph 2. above.

c. Any surgical procedure, except as stated in paragraph 2. above or specifically stated in Section 5. WW. (Surgical Services).

d. Tooth extraction of any kind, except as specifically stated in paragraph 2. above.

e. Periodontal care.

P. Diabetes Treatment

1. Definitions. The following definitions apply to this subsection only:

a. Diabetes Self-Management Training: instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Diabetes self-management training shall include the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy.

b. Medical Nutrition Therapy: shall have the meaning ascribed to "medical nutrition care" in the Dietetic and Nutrition Services Practice Act.

2. Covered Diabetes Treatment: We'll pay benefits for charges for the following treatment of Type I diabetes, Type II diabetes and gestational diabetes mellitus:

a. *diabetes self-management training*, including medical nutrition education, shall be limited to the following:

1) up to three (3) visits to a *health care provider* upon initial diagnosis of diabetes by your *health care practitioner*; and

2) up to two (2) visits to a *health care provide*r upon a determination by your *health care practitioner* that a significant change in your symptoms or medical condition has occurred. A "significant change" in

condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.

No additional visits beyond those specified in 1) or 2) above are available under the policy. However, *diabetes self-management training* may be provided as a part of an office visit, group setting, or home visit if authorized by a *health care practitioner*.

b. equipment when prescribed by a *health care practitioner*: (1) blood glucose monitors; (2) blood glucose monitors for the legally blind; (3) continuous glucose monitor; (4) cartridges for the legally blind; and (5) lancets and lancing devices.

c. pharmaceutical and supplies, excluding insulin and disposable diabetic supplies payable elsewhere under the policy, when prescribed by a *health care practitioner*: (1) syringes and needles; (2) test strips for glucose monitors; (3) FDA approved oral agents used to control blood sugar; and (4) glucagon emergency kits.

d. regular foot care exams.

3. Diabetes Services Limitation:

Insulin and certain disposable diabetic supplies are not covered under this section. For coverage of insulin and certain disposable diabetic supplies, see Section 5. PP. (Prescription Legend Drugs and Supplies).

4. Diabetes Services Exclusion:

The Policy provides no *benefits* for the replacement of equipment that is not *medically necessary*. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

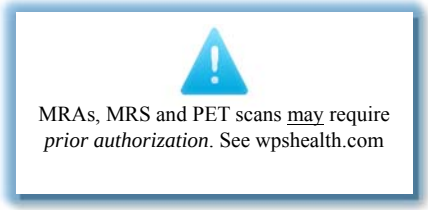
Q. Diagnostic Services (for Genetic Services, see 5. V. below)

1. Covered Diagnostic Services:

a. Radiology (including x-rays and high-technology imaging); and

b. Laboratory services

The services must be directly provided to you and related to a covered *illness* or *injury*.



2. Diagnostic Services Exclusions:

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

a. Charges for computer-aided detection (except for screening mammogram interpretation).

b. Charges for imaging studies not for purposes of diagnosis (e.g. assisting in the design or manufacture of individualized orthopedic implants).

R. Durable Medical Equipment

1. Covered Durable Medical Equipment:

a. Rental of or, at our option, purchase of *durable medical equipment* that is prescribed by a *health care practitioner* and needed in the *treatment* of an *illness* or *injury*.

b. Subsequent repairs necessary to restore purchased *durable medical equipment* to a serviceable condition.

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

d. Breastfeeding equipment, including electric breast pumps, in conjunction with each birth. You have no cost-sharing for breastfeeding equipment provided by a *preferred provider*.

e. Speech aid devices and tracheo-esophageal voice devices required for *treatment* of severe speech impediment or lack of speech directly attributed to *illness* or *injury*.

2. Durable Medical Equipment Limitations:

a. Benefits will be limited to the standard model.

b. If the *durable medical equipment* is purchased, *benefits* are limited to a single purchase of each type (including repair and replacement) every three years.

c. We will pay benefits for only one of the following: a manual wheelchair, a motorized wheelchair, a knee walker, or a motorized scooter.

3. Durable Medical Equipment Exclusions:

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

a. Rental fees that are more than the purchase price.

b. Continuous passive motion (CPM) devices and mechanical stretching devices.

c. Home devices such as: home spinal traction devices or standers; home INR (international normalized ration blood test) monitors; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective disorder; home pneumatic compression devices for DVT (deep vein thrombosis) prevention; cold therapy (application of low temperatures for the skin) including, but not limited to, cold packs, ice packs, cryotherapy; and home automatic external defibrillator (AED).

d. *Durable medical equipment* that has special features that are not *medically necessary*.

e. Durable medical equipment for your comfort, personal hygiene, or convenience including, but not limited to, physical fitness equipment, *health care practitioner*'s equipment, or self-help devices not medical in nature.

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

g. Replacement of equipment that it is not *medically necessary*.

h. Replacement of over-the-counter batteries.

i. Repairs due to abuse or misuse.

j. Devices and computers to assist in communication and speech, except as stated in 2. e. above.

k. Enuresis alarms.

l. Blood pressure cuffs and monitors.

m. Trusses.

n. Ultrasonic nebulizers.

o. Oral appliances for snoring

S. 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 fee billed for use of 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.

   c. *Emergency medical care* resulting from criminal sexual assault or abuse will be paid without cost-sharing from the *covered person*. Any applicable *copayments* or annual *deductible* amounts will be waived.

   d. If you receive covered emergency health care services from a *non-preferred provider*, you will not incur any greater costs than if the covered service had been provided by a *preferred provider*.

2. **Emergency Medical Care Limitations**

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

   b. If an *ambulance service* is called and you are transported to an emergency room, coverage for any *emergency medical care* directly provided to you during your ambulance transport is payable under Section 5. C. (*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, as shown in the Schedule of Benefits.

T. Fertility Preservation Services

1. **Definitions.** The following definitions apply to this subsection only:

   a. Iatrogenic infertility: impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

   b. May Directly or Indirectly Cause: the likely possibility that treatment will cause a side effect of infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

   c. Standard Fertility Preservation Services: procedures based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

2. **Covered Fertility Preservation Services.**

   Medically necessary expenses for *standard fertility preservation services* when a necessary medical treatment *may directly or indirectly cause iatrogenic infertility* to a *covered person*.

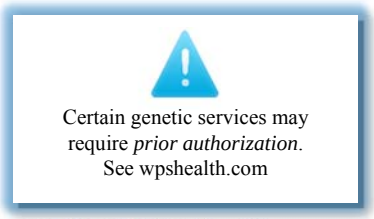
In determining coverage for *standard fertility preservation services*, we shall not discriminate based on your expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, or marital status.

U. Fibrocystic Breast Condition

Health care services for fibrocystic breast conditions in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the *covered person's* medical history is able to confirm a chronic, relapsing, symptomatic breast condition.

V. Genetic Services

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



We may authorize *genetic testing* if the ordering *health care provider* shows that the results of such testing will directly impact your future *treatment*. Your *health care practitioner* must describe how and why, based on the results for the *genetic testing* results, your individual *treatment* plan would be different than your current or expected *treatment* plan based on a clinical assessment without *genetic testing*. Upon request, the ordering *health care provider* must submit information regarding the *genetic testing's* clinical validity and clinical utility. *Genetic testing* that we consider *experimental/investigational/unproven* will not be covered. We will not accept *prior authorization* requests from the laboratory that will perform the genetic services, unless there is supporting documentation from the ordering *health care provider.*

For BRCA testing and counseling, see section 5. QQ. (Preventive Care Services).

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 the influenza and hepatitis virus. Panel testing for multiple agents are not covered without justification by your *health care practitioner* for each test composing the panel;

e. Compatibility testing for a covered person who has been approved by us for a covered transplant;

f. Cystic fibrosis testing and spinal muscular atrophy as recommended by the American College of Medical Genetics;

g. Molecular genetic testing of pathological specimens (such as tumors). All other molecular testing of blood or body fluids require prior authorization unless the test is otherwise specified on our website wpshealth.com. Please note that many molecular tumor profiling tests and gene-related or panel tests are not covered; and

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

2. Genetic Services Exclusions:

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

a. *Genetic testing* for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone.

b. *Genetic testing* for conditions that cannot be altered by *treatment* or prevented by specific interventions.

c. *Genetic testing* solely for the purpose of informing the care or management of your family members.

d. *Genetic counseling* performed by the laboratory that performed the genetic test.

e. *Genetic testing* that is not supported by documentation from the ordering *health care provider.*

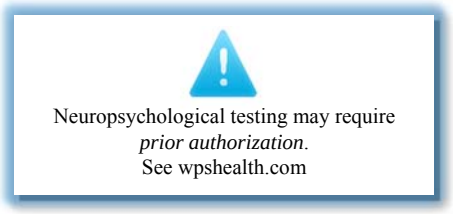
W. Habilitative Services for Children

Benefits for habilitative services for *eligible dependent children* with a congenital, genetic, or *early acquired disorder* are the same as your *benefits* for any other condition if all of the following conditions are met:

1. A *health care practitioner* has diagnosed the congenital, genetic, or *early acquired disorder*; and
2. *Treatment* is administered by a *health care practitioner* upon the referral of a *health care practitioner*; and
3. *Treatment* must be *medically necessary* and therapeutic and not *experimental/investigational/unproven*.

This subsection applies only if charges for habilitative services are not covered elsewhere under the Policy and are not educational in nature.

X. Health and Behavior Assessments



1. **Covered Health and Behavior Assessments:**

   a. Health and behavior assessments and reassessments;

   b. Diagnostic interviews;

   c. Neuropsychological testing.

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

2. **Health and Behavior Assessments Exclusions:**

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

a. Intensive inpatient treatment by a psychologist to treat a medical condition.

b. Baseline neuropsychological testing, for example, ImPACT® Immediate Post-Concussion Assessment and Cognitive Testing.

Y. Hearing Aids, Implantable Hearing Devices and Related Treatment

1. **Definitions:**

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

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

   c. Hearing Care Professional: a person who is a licensed hearing instrument dispenser, licensed audiologist, or a licensed *physician.*

   d. Hearing Aid/Hearing Instrument: any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold but excluding batteries and cords.

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

2. Covered Hearing Services:

a. Any of the following when prescribed by a *health care practitioner* or *licensed hearing professional:*

1) One *hearing aid* or *hearing instrument* (including fitting and testing), for each ear, per *covered person* once every thirty-six months;

2) Related services for the *hearing aid/hearing instrument* such as audiological exams and selection, fitting, and adjustment of ear molds to maintain optimal fit when deemed *medically necessary* by a *hearing care professional*;

3) Repairs of *hearing aids/hearing instruments* when deemed *medically necessary*.

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

1) *Implantable hearing devices*;

2) Treatment related to *implantable hearing devices* covered under this subsection, including procedures for the implantation *of implantable hearing devices*.

3) Post-cochlear implant aural therapy.

3. Hearing Services Exclusions:

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

a. Hearing protection equipment.

b. *Hearing aid* batteries and cords.

Z. Home Care Services

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

1. Definitions:

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

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

2. Covered Home Care Services:

a. Home safety evaluations, evaluations for a home treatment program, and/or initial visit(s) to evaluate you for an independent treatment plan;

b. Part-time or intermittent home nursing care by or under supervision of a registered nurse;

c. Part-time or intermittent *home health aide services* that consist solely of care for the patient as long as they are: (1) *medically necessary*; (2) appropriately included in the home care plan; (3) necessary to prevent or postpone confinement in a *hospital* or *skilled nursing facility*; and (4) supervised by a registered nurse or medical social worker.

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

e. Medical supplies, drugs and medications prescribed by a *health care practitioner*; laboratory services by or on behalf of a *hospital* if needed under the *home care* plan. These items are covered to the extent they would be if you had been hospitalized;

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

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.

3. Home Care Limitations:

a. Each visit by a person to provide services under a *home care* plan, to evaluate your need for *home care*, or to develop a *home care* plan counts as one home care visit. Each period of up to four straight hours of *home health aide services* in a 24-hour period counts as one *home care* visit.

b. The maximum weekly benefit payable for *home care* won't be more than the benefits payable for the total weekly charges for *skilled nursing care* available in a licensed skilled nursing facility.

4. Home Care Exclusions:

The Policy provides no *benefits* for 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 due to an *illness* or *injury* or because leaving his/her home would be contraindicated.

AA. Home Intravenous (IV) Therapy or Infusion Therapy

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

BB. Hospice Care

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

2. Covered Hospice Care Services:

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

b. *Covered expenses* for *hospice care* will include:

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

2) *Health care practitioner* and nursing care; and

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

c. We will pay benefits for charges for covered expenses for *hospice care* services provided to you during the initial one-year period immediately following the diagnosis of a terminal illness. Coverage for *hospice care* services

after the initial one-year period will be extended by us under the Policy beyond the initial one-year period, provided, a *health care practitioner* certifies in writing that you are terminally ill.

3. **Hospice Care Services Exclusions:**

The Policy provides no *benefits* for the items listed below. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Room and board for residential care at a *hospital* facility. See Section 5. CC. (Covered Expenses / Hospital Services).

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

CC. Hospital Services

Transplant services are not covered under this section. Please see Section 5. AAA. (Transplants) for this coverage information. This section also does not include *charges* for outpatient physical, speech, or occupational therapy. Please see Section 5. ZZ. (Therapy Services).

1. **Covered Hospital Services:**

a. Inpatient Hospital Services. *Benefits* are payable for the following inpatient *hospital* services for an *illness* or *injury,* including detoxification:

1) *charges* for room and board for a semi-private or private room;

2) *charges* for nursing services;

3) *charges* for miscellaneous *hospital* expenses, including preadmission testing;

4) *charges* for intensive care unit room and board; and

5) *charges* for *hospice care* when your condition requires inpatient *hospital* care.

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

1) Surgery and any related diagnostic service received on the same day as the surgery;

2) Radiation therapy treatments;

3) Chemotherapy; and

4) Electroconvulsive therapy.

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

2. **Partial Hospital Treatment Program.** Benefits are payable for a *partial hospitalization treatment program* approved by us.

3. **Residential Treatment Center.** Benefits are payable for inpatient treatment in a residential treatment center licensed by the Department of Public Health or the Department of Human Services for *substance use disorders*.

4. **Hospital Services Limitations:**

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

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

5. **Hospital Services Exclusions:**

   The Policy provides no *benefits* for the items listed below. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

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

   b. *Health care services* received during an inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of a *mental illness disorder*. This does not include services or supplies provided for the treatment of an *injury* resulting from an act of domestic violence or a medical condition (including both physical and behavioral health conditions).

   c. Charges for outpatient physical, speech, or occupational therapy.

DD. Immune Gamma Globulin Therapy

Immune gamma globulin therapy for *covered persons* diagnosed with a primary immunodeficiency when prescribed as *medically necessary* by a *health care practitioner*. Following the initial diagnosis, we will authorize a minimum of three (3) months of immune gamma globulin therapy with subsequent reauthorization occurring no greater than every six (6) months. Following two (2) years of authorized immune gamma globulin therapy with sustained beneficial response based on the treatment notes or clinical narrative detailing progress to date, we will require reauthorization no greater than every 12 months.

EE. Infertility Services

1. **Definitions.** The following definitions apply to this subsection only:

   a. Artificial Insemination (Al): the introduction of sperm into a woman's vagina or uterus by noncoital methods for the purpose of conception.

   b. Assisted Reproductive Technologies (ART): treatments and/or procedures in which the human *oocytes* and/or sperm are retrieved, and the human *oocytes* and/or *embryos* are manipulated in the laboratory. ART shall include prescription drug therapy used during the cycle where an *oocyte retrieval* is performed.

   c. Donor: an *oocyte donor* or sperm *donor*.

   d. Embryo: a fertilized egg that has begun cell division and has completed the pre-embryonic stage.

   e. Embryo Transfer: the placement of the pre-*embryo* into the uterus or, in the case of *zygote intrafallopian tube transfer*, into the fallopian tube.

   f. Infertility: the inability to conceive after one year of *unprotected sexual intercourse* or the inability to sustain a successful pregnancy. For purposes of this subsection, a woman shall be considered infertile without having to engage in one year of *unprotected sexual intercourse* if a *health care practitioner* determines that:

      1) a medical condition exists that renders conception impossible through *unprotected sexual intercourse*, including but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments; or

2) efforts to conceive as a result of one year of medically based and supervised methods of conception, including *artificial insemination*, have failed and are not likely to lead to a successful pregnancy.

g. In Vitro Fertilization (IVF): a process in which an egg and sperm are combined in a laboratory dish where fertilization occurs. The fertilized and dividing egg is transferred into the woman's uterus.

h. Low Tubal Ovum Transfer: the procedure in which *oocytes* are transferred past a blocked or damaged section of the fallopian tube to an area closer to the uterus.

i. Oocyte: the female egg or ovum, formed in an ovary.

j. Oocyte Donor: a woman determined by a *health care practitioner* to be capable of donating eggs in accordance with the standards recommended by the American Society for Reproductive Medicine.

k. Oocyte Retrieval: the procedures by which eggs are obtained by inserting a needle into the ovarian follicle and removing the fluid and the egg by suction. This is also called ova aspiration.

l. Surrogate: a woman who carries a pregnancy for a woman who has *infertility* coverage.

m. Unprotected Sexual Intercourse: should include appropriate measures to ensure the health and safety of sexual partners and means sexual union between a male and a female, without the use of any process, device or method that prevents conception, including but not limited to oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures.

n. Uterine Embryo Lavage: a procedure by which the uterus is flushed to recover a preimplantation *embryo*.

o. Zygote: a fertilized egg before cell division begins.

p. Zygote Intrafallopian Tube Transfer (ZIFT): a procedure by which an egg is fertilized in vitro, and the *zygote* is transferred to the fallopian tube at the pronuclear stage before cell division takes place. The eggs are harvested and fertilized on one day and the *embryo* is transferred at a later time.

2. Covered Infertility Services: We'll pay benefits for charges for all diagnosis and treatment of *infertility*, including, but not limited to, *in vitro fertilization*, *uterine embryo lavage*, *embryo transfer*, *artificial insemination*, gamete intrafallopian tube transfer, *zygote intrafallopian tube transfer*, *low tubal ovum transfer*, and *assisted reproductive technologies.* Benefits shall be limited to the following:

a. For treatments that include *oocyte retrievals*, coverage for such treatments shall be covered only if you have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate *infertility* treatments. This requirement shall be waived in the event that you or your partner has a medical condition that renders such treatment useless.

b. Four completed oocyte retrievals, except if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals will be allowed per calendar year.

c. Procedures performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for *in vitro fertilization* clinics or to the American Fertility Society minimum standards for programs of *in vitro fertilization*.

d. C*harges* for an *oocyte donor* or sperm *donor* for procedures utilized to retrieve *oocytes* or sperm, and the subsequent procedure used to transfer the *oocytes* or sperm to the *covered person*. This may include associated *donor charges*, but not limited to physical examination, laboratory screening, psychological screening, and prescription drugs, if established as prerequisites to donation by us.

3. Infertility Limitations

a. Services or supplies rendered to a *surrogate*, except that costs for procedures to obtain eggs, sperm or *embryos* from you will be covered if you choose to use a *surrogate*.

b. Selected termination of an *embryo*; provided, however, termination will be covered where the mother's life would be in danger if all *embryos* were carried to full term.

4. **Infertility Exclusions:**

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

   a. Expenses incurred for cryo-preservation or storage of sperm, eggs or *embryos*, except for those procedures which use a cryo-preserved substance.

   b. Non-medical costs of an egg or sperm *donor*.

   c. Travel costs for travel within 100 miles of your home or travel costs which are not *medically necessary*

   d. *Infertility* treatments which are deemed investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

   e. *Infertility* treatment rendered to your *dependents* under age 18.

FF. 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. AAA. (Transplants).

GG. Mastectomy Treatment

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

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Breast prostheses; and
4. *Treatment* of physical complications for all stages of mastectomy, including lymphedemas.
5. Inpatient *hospital* services following a mastectomy for a length of time determined by the attending *health care practitioner* to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the patient; and
6. A post discharge *health care practitioner* office visit or in-home nurse visit to verify the condition of the covered person in the first 48 hours after discharge.

When there is no evidence of malignancy, these covered services can be provided after the date of the mastectomy, provided the Policy is in force for the *covered person* during that period.

HH. Maternity Services

1. **Covered Maternity Services includes services for both the mother and newborn(s):**

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

      1) Global maternity *charge*. The global maternity *charge* is a unique procedure billed by a *health care practitioner* that includes prenatal care, delivery, and one postpartum care *office visit*. Examples of *health care services* for this procedure may include the prenatal physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis. Monthly *office visits* up to 28 weeks, biweekly *office visits* to 36 weeks, and weekly *office visits* until delivery are also included.

      2) *Charges* by a *hospital* for vaginal or cesarean section delivery.

      3) Exams and testing that are billed separately from the global maternity fee.

4) Health care services for miscarriages.

5) *Health care services* related to an abortion provided the abortion procedure for the termination of a mother's pregnancy is: (a) considered a life-threatening complication of the mother's existing *physical illness*; or (b) a result of rape or incest; and (c) the abortion procedure is permitted by and performed in accordance with law.

b. With respect to *health care services* provided to a newborn during the inpatient stay in the *hospital, charges* will apply to the mother's *deductible* and annual *out-of-pocket limits* until either 48 hours have passed after a normal birth or 96 hours have passed for a cesarean delivery.

c. With respect to *confinements* for pregnancy, the Policy will not limit the length of stay to less than: (1) 48 hours for a normal birth; and (2) 96 hours for a cesarean delivery. However, a mother is free to leave the *hospital* earlier if she and her *health care practitioner* mutually agree to shorten the stay.

2. Maternity Exclusions:

The Policy provides no *benefits* for 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 paragraph 1. a. above.

c. Home births.

d. Continued *hospital* stay for the mother solely because her newborn infant remains hospitalized.

e. Continued *hospital* stay for the newborn infant solely because the mother remains hospitalized.

II. Medical Services

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

2. *Medical services* for an *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*, in your home; or in a *partial hospitalization treatment program*. *Medical services* covered under this section do not include *health care services* covered elsewhere in the Policy, including *home care* services covered under Section 5. Z. (Home Care Services).

JJ. Medical Supplies

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

a. Strapping and crutches;

b. Ostomy bags and *supplies*;

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, limited* to two pairs per covered person per calendar year.

e. enteral therapy supplies;

f. urinary catheters and supplies;

g. amino acid-based elemental formulas regardless of the delivery method, for the diagnosis and treatment of: 1) eosinophilic disorders; and 2) short bowel syndrome when the prescribing *health care practitioner* has issued a written order stating that the amino acid-based elemental formula is *medically necessary*.

2. Medical Supplies Exclusions:

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

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

b. Charges for ostomy *supplies* such as those made by a pharmacy for purposes of a fitting.

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

KK. Naprapathic Services

1. Definitions

a. Naprapath: an individual who is licensed as a naprapathy under Illinois statutes, as amended or the laws and regulations of another state.

b. Naprapathic Services: the performance of *naprapthic* practice by a *naprapath* which may legally be rendered by them.

2. Covered Naprapathic Services. *Naprapathic services* provided by a *naprapathy*, limited to 15 visits per *covered person* per *calendar year*.

LL. Nutritional Counseling

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

MM. Orthotic Devices

1. Covered Orthotic Devices:

a. a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces.

b. adjustments, repairs or replacement of the device because of a change in your physical condition, as medically necessary.

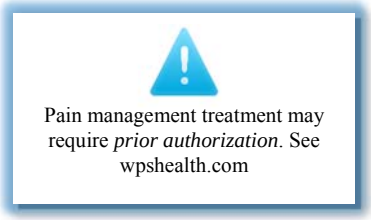
Orthotic devices may be replaced once per *calendar year* per *covered person.* The replacement must be *medically necessary*. Additional replacements will be allowed: 1) if you are under age 19 due to rapid growth; or 2) when a device or appliance is damaged and cannot be repaired.

2. Orthotic Devices Exclusion:

The Policy provides no *benefits* for routine periodic maintenance, such as testing, cleaning and checking of the device. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

NN. Pain Management Treatment

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



1. **Definition of 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.

2. **Covered Palliative Care Services**: We will cover *palliative care* that is otherwise a *covered expense* under the Policy.

OO. Pediatric Autoimmune Neuropsychiatric Treatment.

Treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy.

PP. Prescription Legend Drugs and Supplies

Additions to our formulary may occur at any time throughout the year. Deletions will only be made semiannually.

1. **Definitions. The following definitions apply to this subsection PP. only:**

   a. **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. Biosimilars may be classified as *brand-name*, *generic*, and /or as a *specialty drug*.

   b. **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 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.

   c. **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 the *generic drug's* price is comparable to the price of its *brand-name* equivalent. The term *generic drug* may also include over-the-counter drugs that are covered drugs.

   d. **Home Delivery Pharmacy:** a *preferred pharmacy* that dispenses extended *supplies* of maintenance medications (typically greater than a 30 to 34-day supply).

   e. **Preferred Drug(s):** any *generic drug* or *brand-name drug* named on our list of *preferred drugs*, which is available at wpshealth.com. The list of *preferred drugs* may change from time to time.

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

   g. **Prescription Legend Drug**: drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

   h. **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.

   i. **Preventive Drugs:** drugs that we are currently required by law to define as preventive drugs, including: (1) aspirin for the prevention of cardiovascular disease (age 50-59) and after 12 weeks of gestation in women who are at high

risk for preeclampsia; (2) fluoride supplements if you are older than six months; (3) folic acid for women planning or capable of pregnancy; (4) oral contraceptives, contraceptive patches, contraceptive devices (e.g., diaphragms, sponges and, gel) and contraceptive vaginal rings for birth control; (5) nicotine replacements (e.g., patches and gum) and covered drugs used for smoking cessation if you are age 18 and over; 6) Vitamin D if you are age 65 and over and are at an increased risk for falls; (7) risk reducing medications, such as tamoxifen or raloxifene, for women who are at increased risk for breast cancer and at low risk for adverse medication effects; (8) immunizations and (9) low/moderate dose statins for ages 40-75 with at least one cardiovascular disease risk factor and a 10-year calculated cardiovascular risk of at least 10%. The USPSTF may change the definition of *preventive drugs* during the course of the year. Please see www.uspreventivetaskforce.org.

j. **Specialty Drugs:** *prescription legend drugs* are: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost. If you want to know if a drug is a specialty drug and if that specialty drug requires our *prior authorization*, visit our website at wpshealth.com or call the telephone number shown on your identification card.

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

l. **Specialty Pharmacy:** a *preferred pharmacy* and 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.

2. Covered Drugs:

a. Any *prescription legend drug* not otherwise excluded or otherwise 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/investigative/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. *Prescription legend drugs* used in the treatment of cancer that may not currently have FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis.

g. An immunization that is not excluded elsewhere in the Policy;

h. Topical eye medications to treat a chronic condition of the eye;

i. Opioid antagonists;

j. Oral chemotherapy drugs, intravenously administered cancer medications, or injected cancer medications that are used to kill or slow the growth of cancerous cell;

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

l. Self-injectable medications.

3. 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; and

g. Glucose control solution.

4. **Our Discretion.** We may cover drugs or *supplies* that vary from the *benefits* described in the Policy if there is an advantage to both you and us.

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

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

   a. Not Using Preferred Pharmacies. If drugs and *supplies* are dispensed to you by someone other than a *preferred pharmacy*, *home delivery pharmacy*, or *specialty pharmacy*, you must pay for the drugs or *supplies* up front. To receive reimbursement, you must send us, or our *delegate* a claim with written proof of payment and enough detail to allow us to process the claim. After we receive your claim and supporting documentation, we will determine if *benefits* are payable for the drug or *supply*. If so, we will pay you the *benefit* amount that we would have paid had you purchased the covered drug or *supply* from a *preferred pharmacy*. You are responsible for the applicable *copayment*, *deductible*, or *coinsurance* if applicable, and any difference between our *benefit* payment and the price you paid for the covered drug or *supply*.

   b. Covered Drugs Available from a Home Delivery Pharmacy. If any covered drug is available through a *home delivery pharmacy*, we will only cover three fills at a retail pharmacy unless you have opted-out of the *home delivery pharmacy* program. To opt out of the *home delivery pharmacy program*, you may contact our *delegate* directly by calling 877-603-1032; or call the telephone number shown on your identification card.

   c. Step Therapy. If there is more than one *prescription legend drug* is safe and effective for the *treatment* of your *illness* or *injury*, we may only provide *benefits* for the less expensive *prescription legend drug*. Alternatively, we may require you to try the less expensive *prescription legend drug(s)* before *benefits* are payable for any other alternative *prescription legend drug(s)*.

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

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

   After receiving the required information, if the drug is a covered drug, then it will be covered under the Policy and we will notify you that the drug is covered. If the drug is not a covered drug or is otherwise excluded under the Policy, no *benefits* will be payable for that drug.

   e. Prescription Legend Drugs When Lower Cost Equivalents Are Available. If you obtain a *prescription legend drug* and a lower cost equivalent drug (e. g. *generic drug* or *biosimilar*) is available, you must pay the difference in cost between the between the drug obtained and its equivalent plus the applicable *copayment*/*deductible/coinsurance* amount. Determination that a drug is equivalent must be supported by scientific evidence and/or determinations by regulatory entities such as the FDA. However, this limitation will not

apply to immunosuppressant drugs related to covered transplant services if your *health care practitioner's* instructions are "May Not Substitute" indicating that you use only the *brand-name drug*.

For *preventive drugs*, coverage is also generally limited to generic drugs when they are available. If, however, your *health care practitioner* submits proof to us that it is *medically necessary* for you to use a *preventive drug* that is a *brand-name drug* instead of the equivalent generic drug, 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. We may enforce additional quantity limits on specific drugs to ensure the appropriate amounts are dispensed. Please note that in certain circumstances, we may approve a partial amount (*i.e.* less than a 30-day supply) of a *specialty drug* until you are tolerating the *specialty drug.* In this case, your financial responsibility will be prorated.

Item	**Quantity Limit**
Prescription legend drugs or *supplies* dispensed by a *preferred pharmacy*	30-day supply per fill or refill
Prescription legend drugs (other than *specialty drugs*) or *supplies* dispensed by a *home delivery pharmacy*	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 *calendar year*; and 180-day supply of another type of covered tobacco cessation drug (*e.g.*, varenicline or bupropion) per *covered person* per *calendar year*
Specialty drugs	30-day supply per fill or refill, except as noted above
Blood glucose monitor dispensed by a *preferred pharmacy*	One per *covered person* per *calendar year*
Contraceptives	12-month supply

g. Miscellaneous. *Copayment* or *coinsurance* applies to each cycle of hormone replacement therapy.

h. Limitations on Covered Drugs and Covered Supplies Provided by a Provider Other than a Pharmacy. If a *prescription legend drug* can safely be administered in a lower-cost place of service, for example: (1) a *preferred pharmacy* where the drug can be obtained for self-administration; or (2) by a *home care* company, *benefits* for such *prescription legend drugs* purchased from and administered by a *health care provider* in a higher-cost place of services will not be covered. However, we may allow initial dose(s) of a drug to be administered by a *health care provider* in a higher-cost place of service in certain limited circumstances (for example teaching/training purposes).

7. Medical Exceptions Process.

a. You, or your *authorized representative*, may request any clinically appropriate prescription drug when:

1) the drug is not covered based on the policy's formulary;

2) The Policy is discontinuing coverage of the drug on the formulary for reasons other than safety or other than because the prescription drug has been withdrawn from the market by the drug's manufacturer;

3) The prescription drug alternatives required to be used in accordance with a step therapy requirement: (a) has been ineffective in the treatment of your illness or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the *covered person*, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or (b) has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to you; or

4) The number of doses available under a dose restriction for the prescription drug: (a) has been ineffective in the treatment of your illness; or (b) based on both sound clinical evidence and medical and scientific evidence, the known relevant physical and mental characteristics of the *covered person*, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.

b. A request for a medical exception and approval of coverage must be made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time. Such request will be reviewed by an appropriate health care professional.

c. Within 72 hours of receipt of the request, we will either approve or deny the request. If we deny the request, we shall provide you or your *authorized representative* and the prescribing provider with the reason for denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

d. In the case of an expedited coverage determination, we will either approve or deny the request within 24 hours after receipt of the request. In the case of a denial, we will provide the *covered person* or the *covered person's authorized representative* and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

e. In the case of a step therapy requirement exception, we will approve the request if: 1) the required prescription drug is contraindicated; 2) the *covered person* has tried the required prescription drug while covered under the current Policy or previous health benefit plan and the prescribing *health care provider* submits evidence of failure or intolerance; or 3) if the *covered person* is stable on a prescription drug selected by his or her *health care provider* for the medical condition under consideration while on a current or previous health benefit plan.

f. If we continue to deny a medical exception following an appeal of our original decision, the *covered person*, his or her *authorized representative* or their prescribing *health care provider* may request an external exception review request. We will make a coverage determination no later than 72 hours following our receipt of the external exception review request. If the original appeal request was an expedited coverage determination we will complete the external exception review request within 24 hours following our receipt of the request.

8. Synchronization of Prescription Drug Refills.

Synchronization Definition: the coordination of medication refills when a *covered person* is taking two or more medications for one or more chronic conditions and the *covered person*'s medications are refilled on the same schedule for a given time period.

Synchronization of prescription drug refills will be allowed on at least one occasion per *covered person* per year, provided all of the following conditions are met:

The prescription drugs are covered by the Policy's clinical coverage policy or have been approved by a formulary exceptions process;

a. The prescription drugs are maintenance medications as defined by the Policy and have available refill quantities at the time of synchronization;

b. The medications are not Schedule II, III, or IV controlled substances;

c. The *covered person* meets all utilization management criteria specific to the prescription drugs at the time of synchronization;

d. The prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization; and

e. The prescription drugs do not have special handling or sourcing needs as determined by the policy, contract, or agreement that require a single, designated pharmacy to fill or refill the prescription.

When necessary to permit synchronization, the Policy shall apply a prorated daily cost-sharing rate to any medication dispensed by a *preferred pharmacy* pursuant to this Section 5. PP. No dispensing fees shall be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

9. Prescription Legend Drugs and Supplies Exclusions.

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

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

b. More than three fills of a maintenance medication at a retail pharmacy, unless you have opted-out of the *home delivery pharmacy* program;

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

d. Refills of otherwise covered drugs which exceed the number your *prescription order* calls for;

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

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

g. 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*;

h. Anabolic drugs, unless they are being used for accepted medical purposes and eligible for coverage under the Policy;

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

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

k. Any drug or medicine that is available in prescription strength without a prescription;

l. More than one prescription for the same covered supply, covered drug or therapeutic equivalent medication prescribed by one or more *health care providers* until you have used at least 75% of the previous retail prescription. If the covered supply, drug or therapeutic equivalent medication is dispensed by a *home delivery pharmacy*, then you must have used at least 75% of the previous prescription. This does not apply if the drug(s) meet the criteria stated in 8. above or if it is an inhalant that enables a *covered person* to breathe when suffering from asthma or other life-threatening bronchial ailments;

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

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

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

p. Any drug used for sexual dysfunction or to enhance sexual activity, regardless of why the drug is being prescribed to you;

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

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

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

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

u. All medicinal foods, enteral feedings, supplemental feedings, nutritional and electrolyte supplements, and infant formula, except as specifically stated in the Policy;

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

w. Any drug in unit-dose packaging except as required by law; and

x. Blood derivatives which are not classified as drugs in the official formularies.

QQ. Preventive Care Services

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

1. **Definition of 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, or (d) extend life expectancy.

2. **Covered *Preventive Care Services* for Adults:**

   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, including but not limited to:

   1) Abdominal aortic aneurysm screening in men ages 65 to 75 years who have never smoked;

   2) Alcohol misuse: screening and counseling for all adults age 18 and older;

   3) Aspirin prevention medication for adults aged 50-to 59 who have a 10% or greater 10-year cardiovascular risk;

   4) Bacteriuria screening in pregnant women;

   5) Blood pressure screening in adults age 18 and over;

   6) Bone mass measurements;

   7) BRCA risk assessments and genetic counseling/testing;

   8) Breast cancer preventive medications;

   9) Breast cancer screening;

   10) Cervical cancer screenings;

   11) Chlamydia screening in women who are at an increased risk;

   12) Cholesterol screening;

   13) Colorectal cancer exams, testing and screenings;

   14) Depression screening;

   15) Diabetes screening for adults aged 40 to 70 who are overweight or obese;

   16) Diabetes (Type 2) screening for adults with high blood pressure;

   17) Diet counseling for adults at higher risk for chronic disease;

   18) Falls prevention in older adults, such as exercise interventions to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;

19) Vitamin D supplements for in community-dwelling adults age 65 and older;

20) Folic acid supplementation for women planning or capable of becoming pregnant;

21) Gestational diabetes mellitus screening in asymptomatic pregnant women after 24 weeks of gestation;

22) Gonorrhea screening in women who are sexually active for when 24 years or younger and in older women who are at an increases risk for infection;

23) Healthy diet and physical activity counseling to prevent cardiovascular disease;

24) Hepatitis B screening;

25) Hepatitis B screening in pregnant women;

26) Hepatitis C virus infection screening in adults;

27) HIV screening;

28) HIV screening in pregnant women;

29) Immunization vaccines, including, but not limited to:

- **a)** Diphtheria;
- **b)** Haemophilus influenza type b (HIB), one or three doses for at-risk adults at any age depending on indication;
- **c)** Hepatitis A;
- **d)** Hepatitis B;
- **e)** Herpes Zoster (Shingles);
- **f)** Human Papillomavirus (HPV);
- **g)** Influenza (flu shot);
- **h)** Measles;
- **i)** Meningococcal;
- **j)** Mumps;
- **k)** Pertussis;
- **l)** Pneumococcal;
- **m)** Rubella;
- **n)** Tetanus; and
- **o)** Varicella (chicken pox).

30) Lung cancer screening;

31) Obesity screening and counseling;

32) Osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older;

33) Preeclampsia screening in pregnant women;

34) Prenatal HIV testing;

35) Intimate partner violence screening for women of childbearing age;

36) Aspirin after 12 weeks for gestation in women who are a high risk for preeclampsia;

37) Rh incompatibility screening during first visit for pregnancy-related care;

38) Rh incompatibility screening during 24 to 28 weeks' gestation for Rh -negative women;

39) Sexually transmitted infections and counseling;

40) Skin cancer behavioral counseling;

41) Statin prevention medication in adults age 40-75 years with no history of cardiovascular disease, 1 or more risk factors and a calculated 10-year risk of 10% or greater;

42) Tobacco use counseling and interventions;

43) Tuberculosis screening;

44) Syphilis screening; and

45) Sterilization procedures.

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

c. One complete and thorough clinical examination of the breast as indicated by guidelines of practice each *calendar year* performed by a *health care practitioner* to check for lumps and other changes for the purpose of early detection and prevention of breast cancer;

d. Mammograms. *Benefits* shall include: 1) a baseline mammogram for women 35-39 years of age; 2) an annual mammogram for women 40 years if age or older; 3) a mammogram at the age and intervals considered medically necessary by your *health care practitioner* for women under 40 years of age who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors; 4) a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when *medically necessary* as determined by a *physician*; 5) a screening MRI when *medically necessary*, as determined by a *physician*. This includes digital mammography and breast tomosynthesis (digital three-dimensional images of the breast);

e. One routine prostate-specific antigen test and digital rectal examination for males per calendar year;

f. One annual ovarian cancer screening per *calendar year* using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination;

g. Annual screening and counseling for interpersonal and domestic violence;

h. Diagnosis and treatment of osteoporosis; and

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

3. Covered *Preventive Care Services* for Children

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, including but not limited to:

1) Alcohol and drug use assessments for adolescents;

2) Autism screening for children at 18 and 24 months;

3) Behavioral assessments for children ages 0 to 21 years of age;

4) Blood pressure screening for children ages 0 to 21 years of age;

5) Blood screening for newborns ages 3 to 5 days;

6) Cervical Dysplasia screening for children under age 3;

7) Critical Congenital Heart Defect screening for newborns;

8) Depression screening for adolescents;

9) Developmental screening for children under age 3;

10) Dyslipidemia screening for children at higher risk of lip disorders who are age 1 to 21 years;

11) Fluoride chemoprevention supplements for children without fluoride in their water source;

12) Gonorrhea preventive medication for the eyes of all newborns;

13) Hearing screening for newborns;

14) Height, weight and body mass index (BMI) measurements for children ages 0 to 21 years;

15) Hematocrit or hemoglobin screening;

16) Hemoglobinopathies or sickle cell screening;

17) Hepatitis B screening for adolescents between 11 and 17 years of age from countries with 2% or more Hepatitis B prevalence and U. S. born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence;

18) HIV screening for adolescents at higher risk;

19) Hypothyroidism screening for newborns;

20) Immunization vaccines, including, but not limited to

a) Diphtheria;

b) Haemophilus influenza type b;

c) Hepatitis A;

d) Hepatitis B;

e) Human Papillomavirus (HPV);

f) Inactivated Poliovirus;

g) Influenza (flu shot);

h) Measles;

i) Meningococcal;

j) Mumps;

k) Pertussis (whooping cough);

l) Pneumococcal;

m) Rotavirus;

n) Tetanus; and

o) Varicella (chicken pox).

21) Iron supplements for children ages 6 to 12 months who are at risk for anemia;

22) Lead screening for children at risk of exposure;

23) Medical history throughout development for 0-21 years;

24) Obesity screening and counseling;

25) Oral health risk assessment for 0-10 years;

26) Phenylketonuria (PKU) screening in newborns;

27) Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk;

28) Skin cancer behavioral counseling for children ages 6 months up to age 24 who have fair skin to minimize exposure to ultraviolet radiation to reduce risk for skin cancer;

29) Tobacco use counseling and interventions for adolescents and children;

30) Tuberculin testing for children at higher risk of tuberculosis age 0 -21 years; and

31) Vision screening.

b. Routine medical exams, including hearing exams, and any other related *preventive care services.*

4. With respect to women, *preventive care services* and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including, but not limited to**:**

a. Well-woman visits for *preventive care services* which are age and developmentally appropriate, including preconception care and services necessary for prenatal care;

b. Screening for diabetes during and after pregnancy;

c. Human papillomavirus testing beginning at age 30;

d. Counseling on sexually transmitted infections;

e. Counseling and screening for human immune-deficiency virus;

f. Contraceptive methods, patient education and counseling for women with reproductive capacity. See section 5. N. (Contraceptives for Birth Control);

g. Breastfeeding support, including behavioral interventions to promote breast feeding; comprehensive lactation support and counseling by a trained *health care provider* during pregnancy and/or in the postpartum period supplies and counseling;

h. Screening and counseling for interpersonal and domestic violence; and

i. Screening for urinary incontinence.

5. Preventive Care Services Limitation:

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

6. Preventive Care Services Exclusions:

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

RR. Private Duty Nursing Services

1. Covered Private Duty Nursing Services: Private duty nursing services may be provided to you in your home only when the services are of such a nature that they cannot be provided by non- professional personnel and can only be

provided by a licensed *health care provider*. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family.

Private duty nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care.

2. **Private Duty Nursing Limitation:** Benefits for private duty nursing services will not be provided due to the lack of willing or available non-professional personnel.

SS. Prosthetics

1. **Covered Prosthetics:**

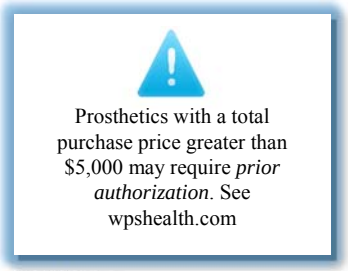
   a. Prosthetic devices and related *supplies,* including the fitting of such devices, that replace all or part of:

      1) an absent body part (including contiguous tissue); or

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

   b. Covered prosthetic devices include, but are not limited to, artificial limbs, eyes, and larynx.

   c. Replacement or repairs of prosthetics which are *medically necessary*.



2. **Prosthetics Exclusions:**

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

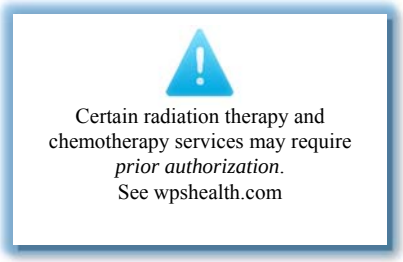
   a. Prosthetics which have special features that are not *medically necessary*.

   b. Dental prosthetics.

   c. Repairs due to abuse or misuse.

TT. Radiation Therapy and Chemotherapy Services

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



UU. Reconstructive Procedures

1. **Covered Reconstructive Procedures**

   a. Reconstructive procedures are covered when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function.

   b. Reconstructive procedures include *reconstructive surgery* or other procedures which are associated with an *injury*, *illness* or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.

2. **Excluded Reconstructive Procedures**

   a. Cosmetic procedures;

   b. *Reconstructive surgery* for the sole *treatment* of a psychological condition (*e.g.* psychological reaction to appearance or fear of disease) or *reconstructive surgery* for purposes other than those stated in paragraph 1. b. above.

VV. Skilled Nursing Care in a Skilled Nursing Facility

1. **Covered Skilled Nursing Care:**

   a. *Skilled nursing care* provided to you in a *skilled nursing facility*.

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

2. **Skilled Nursing Care Exclusions:**

   The Policy provides no *benefits* for 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. Y.), or 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 provided under a governmental health care program.

WW.Surgical Services

This subsection WW. does not include *surgical services* for: (1) covered transplants; (2) pain management procedures; or (3) reconstructive procedures. Please see Section 5. NN. (Covered Expenses / Pain Management Treatment), Section 5. AAA. (Covered Expenses /Transplants), Section 5. UU. (Covered Expenses /Reconstructive Procedures) for this coverage information.

1. **Definitions:**

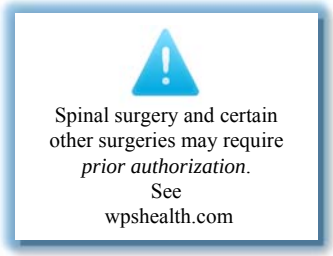
   a. **Incidental/Inclusive:** a procedure or service is *incidental/inclusive* if it is integral to the performance of another *health care service* or if it can be performed at the same time as another *health care service* without adding significant time or effort to the other *health care service*.

   b. **Oral Surgery:** *surgical services* performed within the oral cavity.

   c. **Surgical Services:** (1) an operative procedure performed by a *health care practitioner* and that is recognized for the *treatment* of an *illness* or *injury*; or (2) those services we identify as *surgical services*, including preoperative and postoperative care.

2. **Covered Surgical Services:**

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



   a. *Surgical services*, other than *reconstructive surgery* and *oral surgery*. Covered *surgical services* include but are not limited to:

      1) Operative and cutting procedures;

      2) Assistant at surgery when performed by a *physician*, dentist or podiatrist who assists the operating surgeon in performing covered *surgical services.* This also includes an assistant who is a registered surgical assistant or advanced practice nurse; and a physician assistant under the direct supervision of a *physician*, dentist or podiatrist;

      3) Endoscopic examinations, such as: (a) arthroscopy; (b) bronchoscopy; or (c) laparoscopy; and

      4) Other invasive procedures such as: (a) angiogram; or (b) arteriogram.

b. *Oral surgery*, including related consultation, x-rays and anesthesia (including anesthesia administered by oral and maxillofacial surgeons), limited to the following procedures:

1) Surgical removal of complete bony impacted, sound natural 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 accidental injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth; and

4) Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

c. 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;

d. Congenital heart disease surgeries; and

e. Bariatric surgery.

3. Surgical Services Exclusions:

The Policy provides no *benefits* for 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*. No additional *benefits* are payable for *incidental/inclusive* surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an *incidental/inclusive* surgical procedure; therefore, *benefits* are payable for the hysterectomy, but not for the removal of the appendix.

b. Reversal of a sterilization procedure.

c. *Oral surgery*, except as specifically stated in paragraph 2. b. above.

d. Any *surgical service* which is *cosmetic treatment*, except as otherwise indicated in the Policy.

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

XX. Telemedicine

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

2. Covered Telemedicine Services:

a. Telemedicine services provided by a *health care practitioner* to a *covered person* via interactive audio-visual telecommunication.

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

3. Telemedicine Exclusions:

The Policy provides no *benefits* for the items listed below. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

a. *Telemedicine* services that do not include direct contact between the *health care practitioner* and the *covered person*.

b. Transmission fees.

c. Website charges for online patient education material.

YY. Temporomandibular Joint (TMJ) Disorder Services

1. **Covered TMJ Services:**

   a. Diagnostic procedures and surgical 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; and

      3) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

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

2. **TMJ Services Exclusions:**

   The Policy provides no *benefits* for 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 syndrome, except as specifically stated in paragraph 1. above.

ZZ. Therapy Services

1. **Definitions:**

   a. **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.

   b. ***Preventive Physical Therapy:*** as physical therapy that is prescribed by a *physician* licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals

   c. **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 was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

2. **Covered Therapy Services:**

   a. Outpatient therapy limited as follows:

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

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

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

4) Multiple sclerosis *preventative physical therapy*.

The limits stated in 1), 2), and 3) above do not apply to section 5. D. (Covered Expenses / Autism Services).

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

c. All therapy, except as stated in a. 4) above, must be expected to provide significant measurable gains that will improve your physical health.

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

3. Therapy Exclusions:

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

a. Physical therapy for temporomandibular (TMJ) disorders, except as specifically stated in Section XX. (Temporomandibular (TMJ) Disorder Services).

b. Massage therapy or aquatic therapy, except as specifically stated in paragraph 2. above.

c. Long-term therapy and maintenance therapy, except as specifically stated in paragraph 2. above.

d. Physical, occupational, and speech therapy for conditions including, but not limited to, attention deficit, hyperactivity disorder, sensory defensiveness, auditory defensiveness, mental retardation and related conditions, hearing therapy for communication delay, or therapy for perceptual disorders.

AAA. Transplants

1. Definitions. The following definitions apply to this Section 5. AAA. only:

a. 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.

b. Designated Transplant Facility: a facility that is (1) approved by us to be the most appropriate facility for your approved *transplant services*; (2) contracted to provide approved *transplant services* to *covered persons* pursuant to an agreement with one of our transplant provider networks; (3) a *preferred provider* when transplant services are provided while you are not confined in a *hospital*; or (4) any other *health care provider* approved by us. *Designated transplant facilities* are shown in the Schedule of Benefits as *preferred providers.*

c. Non-Designated Transplant Facility: a facility that does not have an agreement with the transplant provider network with which we have a contract. This may include facilities that are listed as *preferred providers*. *Non-designated transplant facilities* are shown in the Schedule of Benefits as *non-preferred providers.*

d. 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.

e. **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, including but not limited to, immunosuppressant drugs prescribed by a *physician* when you are *confined* in a *hospital*.

2. 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 *medical necessity* criteria for such transplant and may not be *experimental/investigational/unproven*.

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

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

3. Covered Transplants:

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

b. *Covered expenses* for *transplant services* include *health care services* for approved transplants when ordered by a *physician*. *Health care services* include, but are not limited to, *hospital charges*, *physician charges*, *organ and tissue acquisition*, tissue typing, and ancillary services. *Covered transplant drugs* are payable as described in Section 5. PP. (Prescription Legend Drugs and Supplies).

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

1) Kidney;

2) Kidney/pancreas;

3) Pancreas;

4) Liver;

5) Heart;

6) Heart/lung;

7) Lung;

8) Bone marrow (allogenic and autologous);

9) Stem cell transplants;

10) Small bowel transplantation;

11) Cornea; and

12) Artificial or mechanical devices, if approved as a bridge to transplant or destination therapy.

4. Additional Covered Services Related to Transplants:

a. If a *covered person* is the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Policy will be provided for both the *covered person* and the donor. In this case, payments made for the donor will be charged against the *covered person's* benefits.

b. If a *covered person* is the donor for the transplant and no coverage is available to him/her from any other source, the benefits under this Policy will be provided for the *covered person*. However, no benefits will be provided for the recipient.

c. The following additional benefits if you are the recipient of a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant: transportation and lodging for you and a companion. If the recipient of the transplant is a covered dependent, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the hospital where the transplant will be performed. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

5. Transplant Exclusions:

The Policy provides no *benefits* for the items listed below. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Transplants which are *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, implants of artificial or natural organs, except as specifically stated in paragraph 3. above.

d. Lodging expenses, including meals, unless such expenses are covered under the global fee agreement of your transplant network, or those specifically stated in 4. above.

e. Storage fees.

f. Services provided to any person who is not the recipient or actual donor.

g. Meals.

h. Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge for a hospital after a transplant.

i. Transportation benefits of the donor organ shall be limited to the United States and Canada.

BBB. 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.

2. Vision Services Exclusions:

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

a. Vision therapy;

b. Refractive eye surgery, such as radial keratotomy.

c. Orthoptic therapy and pleoptic therapy (eye exercise);

d. Preparation, fitting or purchase of eye glasses or contact lenses, except as specifically stated above;

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

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

CCC. Vision Services – Pediatric

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

a. Routine eye exams.

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

c. Frames from a selection of covered frames limited to one frame per *covered person* per *calendar year*.

d. Contact lenses when purchased in lieu of all other frames and/or lenses. *Benefits* are limited to 48 contact lenses per *covered person* in a *calendar year*.

2. The following services provided you receive our *prior authorization*:

a. Contact lenses for the following conditions:

1) Pathological myopia;

2) Anisometropia;

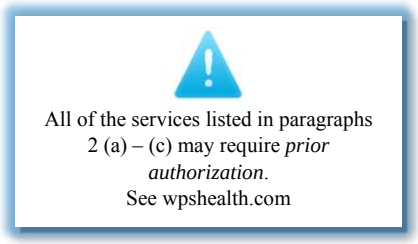
3) Aniseikonia;

4) Aniridia;

5) Corneal disorders;

6) Post-traumatic disorders; and

7) Irregular astigmatism.



b. Low vision services including the following:

1) One comprehensive low vision evaluation every five years;

2) Low-vision aids limited to the following: (a) spectacles; (b) magnifiers; and (c) telescopes; and

3) Follow-up care of four visits in any five-year period.

c. The following lens options and *treatments:*

1) Ultraviolet protective coating;

2) Blended segment lenses;

3) Intermediate vision lenses;

4) Standard progressives;

5) Premium progressives;

6) Photochromic glass lenses;

7) Plastic photosensitive lenses;

8) Polarized lenses;

9) Standard anti-reflective coating;

10) Premium anti-reflective coating;

11) Ultra anti-reflective coating; and

12) Hi-index lenses.

6. GENERAL EXCLUSIONS

The Policy provides no *benefits* for any of the following:

1. Health care services which are not medically necessary**.**

No benefits will be provided for services which are not, in the reasonable judgment of WPS, *medically necessary*. Medically necessary means that a specific medical, health care or hospital service is required, in the reasonable medical judgment of WPS, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided. Hospitalization is not *medically necessary* when, in the reasonable medical judgment of WPS, the medical services provided did not require an acute hospital inpatient (overnight) setting but could have been provided in a *health care practitioner*'s office, the outpatient department of a *hospital* or some other setting without adversely affecting the patient's condition. Examples of hospitalization and other health care services and supplies that are not *medically necessary* include:

a. hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a *health care practitioner*'s office or hospital outpatient department.

b. hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., hospital outpatient department or *health care practitioner*'s office.

c. continued inpatient hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a hospital.

d. hospitalization or admission to a skilled nursing facility, nursing home or other facility for the primary purposes of providing custodial care service, convalescent care, rest cures or domiciliary care to the patient.

e. hospitalization or admission to a skilled nursing facility for the convenience of the patient or *health care practitioner* or because care in the home is not available or is unsuitable.

f. the use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not medically necessary.

We will make the decision whether hospitalization or other health care services or supplies were not medically necessary and therefore not eligible for payment under the terms of your Policy. In most instances, this decision is made by WPS AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your *health care practitioner* may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as medically necessary does not make the hospitalization, services or supplies medically necessary and does not mean that we will pay the cost of the hospitalization, services or supplies.

If your claim for benefits is denied on the basis that the services or supplies were not medically necessary, and you disagree with our decision, your policy provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against us, either at law or in equity. To initiate your appeal, you must give us written notice of your intention to do so within 180 days after you have been notified that your claim has been denied by writing to:

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

You may furnish or submit any additional documentation which you or your *health care practitioner* believe appropriate.

REMEMBER, EVEN IF YOUR *HEALTH CARE PRACTITIONER* PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER *HEALTH CARE SERVICES* AND SUPPLIES AS *MEDICALLY NECESSARY*, WE WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF THEY WERE NOT *MEDICALLY NECESSARY*.

2. Health care services which are experimental/investigational/unproven.

3. Maintenance care or supportive care.

4. *Health care services* which are *cosmetic treatment*, except as otherwise provided in the Policy.

5. *Health care services* or supplies provided in connection with any *illness* or *injury* arising out of, or sustained in the course of, any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance. This exclusion applies regardless of whether benefits under workers' compensation laws or similar laws have been claimed, paid, waived or compromised. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

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 any state or federal law.

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

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

10. *Health care services* for any *illness* or *injury* you sustain: (a) while on active duty in the armed services of any country; or (b) as a result of you being on active duty in the armed services of any country.

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

12. Charges in excess of the *maximum allowable fee* 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 by law. 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* resulting or arising from complications of, or incidental to, any *health care service* not covered under the policy, except from complications of, or incidental to, a *subscriber*'s or his/her *spouse*'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; except as stated in Section 5. RR. (Private Duty Nursing Services).

21. Transportation or other travel costs associated with a *health care service*, except as specifically provided in Sections 5. C. (Covered Expenses / Ambulance Services) and 5. AAA. (Covered Expenses / Transplants).

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. B. (Alternative Care).

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

25. *Health care services* not provided by a *health care practitioner* or any of the *health care providers* listed in Section 5. (Covered Expenses).

26. The following procedures and any related *health care services*:

    a. Injection of filling material (collagen) other than for incontinence;

    b. Salabrasion;

    c. Rhytidectomy (face lift);

    d. Dermabrasion;

    e. Chemical peel;

    f. Suction-assisted lipectomy (liposuction);

    g. Hair removal;

    h. Mastopexy;

    i. Mammoplasty, augmentation or reduction mammoplasty (except when medically necessary or for reconstruction following treatment for breast cancer);

    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 male gynecomastia;

    n. Botulinum toxin or similar products, unless you receive our *prior authorization*;

    o. Any modification to the anatomic structure of a body part that does not affect its function;

    p. Labiaplasty;

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

    r. Medical and surgical *treatment* of excessive sweating (hyperhidrosis).

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

28. *Health care services* provided: (a) in the examination, *treatment* or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting or trimming of toenails; or (c) in the non-operative partial removal of toenails. This exclusion does not apply to *health care services* that are associated with a medical diagnosis of diabetes, peripheral vascular disease or peripheral neuropathy.

29. Housekeeping, shopping, or meal preparation services.

30. *Health care services* provided in connection with: (a) any *illness* or *injury* caused by your engaging in an illegal occupation; or (b) any *illness* or *injury* caused by your commission of, or an attempt to commit, a felony.

31. *Health care services* for which proof of loss is not 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 a local political subdivision.

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

35. *Treatment* of weak, strained, flat, unstable or unbalanced feet; arch supports; heel wedges; lifts; orthopedic shoes; or the fitting of orthotics to aid walking or running; except as specifically stated 5. MM. (Covered Expenses / Orthotic Devices and Appliances).

36. *Health care services* for *treatment* of sexual dysfunction, including impotence, regardless of the cause of the dysfunction. This includes: (a) *surgical services*; (b) devices; (c) drugs for, or used in connection with, sexual dysfunction; (d) penile implants; and (e) sex therapy.

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

38. Salivary hormone testing.

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

40. Prolotherapy.

41. Platelet-rich plasma.

42. Coma stimulation/recovery programs.

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

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

45. Car seats.

46. Modifications to your vehicle, home or property including, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, chair lifts, grab bars, raised toilet seats, commodes, or ramps.

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

48. *Health care services* for holistic, complementary, alternative or homeopathic medicine or other programs that are not accepted medical practice, including, but not limited to, aromatherapy, herbal medicine, reflexology, and programs with an objective to provide personal fulfillment.

49. Hypnosis.

50. Acupuncture.

51. Biofeedback, except for fecal/urinary incontinence.

52. Therapy services such as recreational therapy (other than recreational therapy included as part of a *treatment* program received during an inpatient *hospital confinement* for *treatment* of *mental illness disorders* and/or *substance use disorders*), educational therapy, physical fitness, or exercise programs, except as specifically stated in Section 5. J. (Covered Expenses / Cardiac Rehabilitation Services) and Section 5. ZZ. (Covered Expenses / Therapy Services).

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

54. Vocational or industrial rehabilitation including work hardening programs.

55. Sports hardening and rehabilitation.

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

57. 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.

58. *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. QQ. (Covered Services / Preventive Care Services) and 5. WW. (Covered Expenses / Surgical Services). Services excluded under this provision are not limited to:

- **a.** Liposuction;
- **b.** Any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you;
- **c.** Physical fitness or exercise programs or equipment, unless *benefits* are provided elsewhere in the Policy; and
- **d.** Bone densitometry (DEXA, DXA) scans.

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

60. *Health care services* performed by a *health care provider* with your same legal residence.

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

62. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed *hospice care* agency for which *benefits* are provided as described under Section 5. BB. (Covered Expenses / Hospice Care).

63. *Infertility* treatment, except as specifically stated in Section 5. EE. (Infertility Services) or Section 5. PP. (Covered Expenses / Prescription Legend Drugs and Supplies).

7. COORDINATION OF BENEFITS (COB)

A. Definitions

The following definitions apply to this Section 7. only:

1. **Allowable Expense**: a necessary, reasonable and customary item of for health care, when the item of expense 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 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. 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. This does not include Medicare and Medicaid. It also does not include any *plan* whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

   c. Medical expense benefits coverage in group, group-type and individual automobile "no-fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis are included.

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

4. **Primary Plan/Secondary Plan:** Subsection C. below (Order of Benefit Determination Rules) 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 to this plan when a *subscriber* or the *subscriber's dependent* has 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).

C. Order of Benefit Determination Rules

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

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

b. Both those rules and the Policy's rules described in subsection 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 d. 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.

c. 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.

d. Dependent Child/Separated or Divorced Parents. If two or more *plans* cover a person as a dependent *child* of divorced or separated parents, *benefits* for the *child* are determined in this order:

1) First, the *plan* of the parent with custody of the *child*;

2) Then, the *plan* of the *spouse* or *domestic partner* of the parent with custody of the *child*; and

3) Finally, the *plan* of the parent not having custody of the *child*.

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

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

e. Young Adult/Dependent. For a dependent *child* who has coverage under either or both parents' *plans* and also has his or her own coverage as a dependent under a *spouse*'s *plan*, subsection h. (Longer/Shorter Length of Coverage) applies. In the event the dependent *child*'s coverage under the *spouse*'s *plan* began on the same date as the dependent *child*'s coverage under either or both parents' *plans*, the order of benefits shall be determined by applying the birthday rule of subsection b. (Dependent Child/Parents Not Separated or Divorced) to the dependent *child's* parent or parents and the dependent's spouse.

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

g. 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 f). is ignored.

h. 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.

i. 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 primary.

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. Such other *plan* or *plans* are referred to as "the other *plans*" below.

2. **Reduction in the Policy's Benefits.** The *benefits* of the Policy will be reduced when the sum of the following exceeds the *allowable expenses* in a *claim determination period*:

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

   b. The benefits that would be payable for the *allowable expenses* under the other *plans*, in the absence of provisions with a purpose like that of this section, whether or not 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

WPS has the right to decide which facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming *benefits* under the Policy must give WPS any facts it needs 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, WPS 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. WPS 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 made by WPS is more than we should have paid, we may recover the excess from one or more of:

   a. The persons it has paid or for whom we have paid;

   b. Insurance companies; or

   c. Other organizations.

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

H. Coverage with Medicare

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

1. If the *covered person* (employee or the employee's *spouse*, (not including a *civil union spouse* or *domestic partner*) is age 65 or older and is covered under an employer group health *plan* of an employer that employs at least 20 persons (including part time employees) for a minimum of 20 weeks during the current or preceding *calendar year* and has not elected to have Medicare as the sole source of medical protection.

2. If the *covered person* is: under age 65; covered under an employer group health *plan* of an employer with at least 100 employees because he/she or a covered family member is working as an employee, is the employer (including self-employed persons) or is an individual associated with the employer in a business relationship; and receiving Medicare benefits due to his/her disability. In this case, the employer must have at least 100 people actively employed 50 percent or more of the regular business days in the preceding *calendar year.*

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

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

Per Section 6. (General Exclusions), paragraph 8., if you are enrolled in Medicare as your *primary plan*, this Policy will not cover any expense that Medicare would cover. If the *covered person* (employee or the employee's *spouse*) is eligible but not enrolled in Medicare, this Policy will pay benefits as described in this employer group health plan.

8. WHEN COVERAGE ENDS

A. General Rules

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

1. The date the Policy terminates.

2. The date you die. However, if the covered employee dies, coverage for his/her dependents shall continue until the last day of the 90-day period following his/her death, unless coverage ends earlier as stated below.

3. Th last day of the applicable grace period if the premium required for your coverage has not been paid to us in accordance with the Policy.

4. The date you enter into military service, other than for an assignment of less than 30 days.

5. The last day of the calendar month in which the *subscriber's* employment terminates.

6. The last day of the calendar month in which we become aware 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 the *subscriber* fails to return to work from that leave of absence; or

   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; or

c. subject to a collective bargaining agreement (CBA). In this case, the *subscriber's* coverage will continue as stated in the CBA. The CBA and any supporting documentation must be provided to us upon our request.

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

7. The last day of the month in which we receive the *policyholder's* request to terminate a *covered person's* coverage, unless the *policyholder* specifies a later coverage termination date.

8. The date your coverage is terminated due to *rescission*.

9. For a *subscriber*'s covered dependent, the date the *subscriber*'s coverage terminates under the Policy.

10. For a *subscriber's spouse* or *domestic partner* who is a *covered person*: (a) the date the *subscriber's spouse* is no longer married to the *subscriber* due to divorce or annulment or no longer party to a civil union; or (b) the date the *domestic partner* no longer meets the definition of *eligible dependent*.

11. For a *child* who is a *covered dependent*, the earliest of the following dates:

a. The last day of the calendar month in which the *child* reaches age 26;

b. For step-*children*, the date the *subscriber's spouse* is no longer married to the *subscriber*;

c. For a *child* of a *domestic partner*, the date the *subscriber's domestic partner* no longer meets the definition of an eligible dependent.

d. For the *child* of a *civil union spouse*, the date the *spouse* no longer meets the definition of an *eligible dependent*.

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 us of his/her *dependent* losing status as an *eligible dependent*. If he/she does not so notify us, the *subscriber* will be responsible for any claim payments made during the period of time the *dependent* was not an *eligible dependent*.

B. Special Rules for Disabled Children

If you have *family coverage* under the Policy, an *eligible dependent* who is a *child* may continue coverage under your *family coverage* beyond the limiting age if: (1) the *child's* coverage under the Policy began before he/she reached age 26, or age 30 for military veterans; (2) the *child* is incapable of self-sustaining employment; (3) the *child* is chiefly dependent upon the *subscriber* for support and maintenance; (4) the *child's* incapacity existed before he/she reached age 26; and (5) the *subscriber's family coverage* remains in force under the Policy.

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

C. Special Rules for Full-Time Students Returning from Military Duty

A *full-time student returning from military duty* may continue coverage if he/she ceases to be a *full-time student* due to a *medically necessary* leave of absence. In order to continue coverage, we must receive written documentation and certification of the *medical necessity* of the leave of absence from his/her attending *health care practitioner*.

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

1. He/she advises us that he/she does not intend to return to school full-time;

2. He/she becomes employed full time;

3. He/she obtains other health care coverage;

4. He/she marries and is eligible for coverage under his/her spouse's health coverage;

5. The date coverage of the *subscriber* through whom he/she has dependent coverage under the Policy is discontinued or not renewed; or

6. One year following the date on which he/she ceased to be a *full-time student* due to the *medically necessary* leave of absence if he/she has not returned to school on a full-time basis.

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

D. Extension of Benefits

On the date the policy ends for all covered persons, benefits for charges as provided under the policy will continue for each covered person who, on the date the policy ends, is totally disabled. Benefits continue until the earliest of:

1. The day the covered person is no longer totally disabled;

2. The day on which 12 consecutive months have passed since the date the policy ended;

3. The day on which coverage terminates under the Policy in accordance with the plan's eligibility and termination provisions stated in A. above.

This extension of benefits does not provide coverage for dental services or for any injury or illness other than the covered illness or injury causing the covered person's total disability.

9. CONTINUATION PRIVILEGE

A. Continuation - State Law

1. Continuation of Coverage for You and Your Dependents.

A subscriber may continue his/her coverage under the policy for himself/herself and his/her covered dependents for as long as 12 months when: (a) coverage ends because his/her employment or membership ends or because of a reduction in hours below the minimum required by the policyholder; and (b) the covered employee had been continuously insured under the policy during the entire three-month period ending with such termination.

Continuation of coverage is not available if the covered employee: (a) is covered by Medicare; (b) is covered by similar group coverage that wasn't in effect right before your employment or membership ended or reduction in hours below the minimum required by the policyholder; or (c) was discharged because of the commission of a felony in connection with his/her work, or because of theft in connection with his/her work, for which his/her employer was in no way responsible; provided the covered employee admitted to the commission of the felony or theft or such act has resulted in a conviction or order of supervision by a court of competent jurisdiction.

To elect to continue coverage, the covered employee must send the policyholder: (a) written notice that coverage is to be continued; and (b) the first monthly premium payment.

If the policyholder provides written notice of the right to continue coverage, this election must be made by the later of: (a) 30 days after employment or membership ends or reduction in hours below the minimum required by the policyholder; or (b) 30 days after the policyholder provides a written notice. If the policyholder does not provide written notice, the election must be made no later than 60 days after your employment or membership ends or reduction in hours.

Your continuation coverage will end at midnight of the earliest of: (a) the day any premium is due and unpaid; (b) the day coverage has been continued for 12 months; (c) the day he/she is eligible for Medicare; (d) the day he/she has similar group coverage that was not in effect on the day employment or membership ended or reduction in hours below the minimum required by the policyholder; (e) the day the Policy ends; (f) the day he/she enters the Armed Forces; (g) the day a *spouse* or child is not an eligible dependent.

2. Spousal Continuation Privilege.

If the coverage of the *spouse* of a covered employee should terminate because of the death of the covered employee, a divorce from the covered employee, dissolution of a civil union from the covered employee or the retirement of the covered employee, the former *spouse* or retired employee's *spouse* if at least 55 years of age will be entitled to continue the coverage provided under the Policy for himself/herself and his/her eligible dependents (if family coverage is in effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

a. continuation will be available to you as the former *spouse* of a covered employee or *spouse* of a retired covered employee only if you provide the employer with written notice of the dissolution of marriage or civil union, the death or retirement of the covered employee within 30 days of such event.

b. within 15 days of receipt of such notice, the employer will give written notice to us of the dissolution of your marriage or civil union to the covered employee, the death of the covered employee or the retirement of the covered employee as well as notice of your address. Such notice will include the group number and the covered employee's identification number under the policy. Within 30 days of receipt of notice from the employer, we will advise you at your residence, by certified mail, return receipt requested, that your coverage and your covered dependents under the Policy may be continued. Our notice to you will include the following:

1) a form for election to continue coverage under the policy.

2) notice of the amount of monthly charges to be paid by you for such continuation of coverage and the method and place of payment.

3) instructions for returning the election form within 30 days after the date it is received from us.

c. in the event you fail to provide written notice to us within the 30 days specified above, benefits will terminate for you on the date coverage would normally terminate for a former *spouse* or *spouse* of a retired covered employee under the Policy as a result of the dissolution of marriage or civil union, the death or the retirement of the covered employee. Your right to continuation of coverage will then be forfeited.

d. if we fail to notify you as specified above, all charges shall be waived from the date such notice was required until the date such notice is sent, and benefits shall continue under the terms of the Policy from the date such notice is sent, except where the benefits in existence at the time of our notice was to be sent are terminated as to all covered employees under the policy.

e. if you have not reached age 55 at the time your continued coverage begins, the monthly charge will be computed as follows:

1) an amount, if any, that would be charged to you if you were a covered employee, plus

2) an amount, if any, that the employer would contribute toward the charge if you were the covered employee under the policy. Failure to pay the initial monthly charge within 30 days after receipt of the required notice from us will terminate your continuation benefits and the right to continuation of coverage.

f. if you have reached age 55 at the time your continued coverage begins, the monthly charge will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in e. above will be charged for the costs of administration.

g. if you have not reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

1) if you fail to make any payment of charges when due (including any grace period specified in the policy).

2) on the date coverage would otherwise terminate under the Policy if you were still married to or in a civil union with the covered employee; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the covered employee's death or entry of judgment dissolving the marriage or civil union existing between you and the covered person, except in the event the Policy is modified or terminated.

3) the date on which you remarry or enter another civil union.

4) the date on which you become an insured employee under any other group health plan.

5) the. expiration of 2 years from the date your continued coverage under the policy.

h. if you have reached age 55 at the time your continued coverage begins, your continuation of coverage shall end on the first to occur of the following:

1) if you fail to make any payment of charges when due (including any grace period specified in the policy).

2) on the date coverage would otherwise terminate, except due to the retirement of the covered employee, under the Policy if you were still married to or in a civil union with the covered employee; however, your coverage shall not be modified or terminated during the first 120 consecutive days following the covered employee's death, retirement or entry of judgment dissolving the marriage or civil union existing between you and the covered employee, except in the event the Policy is modified or terminated.

3) the date on which you remarry or enter another civil union.

4) the date on which you become an insured employee under any other group health plan.

5) the date upon which you reach the qualifying age or otherwise establish eligibility under Medicare.

i. if you exercise the right to continuation of coverage under the Policy you shall not be required to pay charges greater than those applicable to any other covered employee covered under the policy, except as specifically stated in these provisions.

j. if the Policy is cancelled and another insurance company contracts to provide group health insurance at the time your continuation of coverage is in effect, the new insurer must offer continuation of coverage to you under the same terms and conditions described in the policy.

3. ***Eligible Dependent Child*** **Continuation Privilege.**

Within 30 days of the death of a subscriber, the *eligible dependent child* who is covered under the Policy (but is not eligible for coverage as a dependent under the provisions of paragraph 2. above) or a responsible adult acting on behalf of the dependent child and seeks continuation coverage shall notify the employer of such death. Within 15 days of receipt of such notice, the employer will send us written notification of the covered employee's death and the address of the dependent child. The employer will also immediately send a copy of such notification to the dependent child or responsible adult at the dependent child's residence.

Within 30 days of a dependent child attaining the limiting age under the policy, if continuation coverage is desired, the dependent child shall give the employer or us written notice of the attainment of the limiting age. Within 15 days of receipt of such notice, the employer will send us written notification of the attainment of the limiting age by the dependent child and of the dependent child's residence.

Within 30 days after the date of receipt of a notice from the employer, dependent child, or responsible adult acting on behalf of the dependent child, or of the initiation of a new group policy, we will send by certified mail, return receipt

requested, shall notify the dependent child or responsible adult at the dependent child's residence that the Policy may be continued for the dependent child, and the notice shall include: (a) a form for election to continue the insurance coverage; (b) the amount of periodic premiums to be charged for continuation coverage and the method and place of payment; and (c) instructions for returning the election form within 30 days after the date it is received from us.

Failure of the dependent child or the responsible adult acting on behalf of the dependent child to exercise the election of continuation insurance coverage by notifying us in writing and payment of the first monthly premium within such 30-day period shall terminate the continuation of benefits and the right to continuation.

If we fail to notify the dependent child or responsible adult acting on behalf of the dependent child within 30 days of our receiving written notice from the employer, all premiums shall be waived from the date the notice was required until notice is sent, and the benefits shall continue under the terms and provisions of the policy, from the date the notice was required until the notice is sent, unless this policy is terminated for all employees.

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

a. failure to pay premiums when due, including any grace period allowed by the policy; or

b. the date the dependent child first becomes an insured employee under any other group health plan;

c. when coverage would terminate under the terms of the existing policy if the dependent child was still an eligible dependent of the covered employee; or

d. the expiration of 2 years from the date continuation coverage began.

Upon the termination of continuation coverage, the dependent child shall be entitled to convert the coverage to an individual policy.

B. Continuation - Federal Law

A *covered person* who is no longer eligible for coverage under the policy, such as a *subscriber* whose employment ends with the policyholder, certain dependent children, or a divorced or surviving *spouse* (excluding a *civil union 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.

Covered persons must contact the policyholder within 60 days of a divorce or a *child* (excluding a *civil union spouse's child*) losing dependent status under the Policy in order to be eligible for COBRA continuation. The *covered person* has 60 days following the termination date to elect to continue coverage under COBRA.

If the *covered person* is 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 will not interfere with the professional relationship you have with your *health care practitioner*, *hospital* or other *health care provider*. We do not require that you choose any particular *health care practitioner*, *hospital*, or other *health care provider*, although there may be different *benefits* payable under the Policy depending on your choice of *health care practitioner*, *hospital*, or other *health care provider*. We do not guarantee the competence of any particular *health care practitioner*, *hospital*, other *health care provider* or their availability to provide services to you. You must choose the *health care practitioner*, *hospital*, or other *health care provider* you would like to see and the *health care services* you wish to receive. We're not responsible for any *injury*, damage or expense (including attorneys' fees) you suffer as a result of any improper advice, action or omission on the part of any *health care practitioner*, *hospital*, or other *health care provider*, including, but not limited to, any *preferred provider*. We 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 practitioner*, *hospitals* and other *health care providers* must release medical records and other claim-related information to us so that *benefits* may be 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 pay *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 Illinois insurance laws and regulations.

E. Reimbursement Rights

If a *subscriber* or one of his/her *covered dependents* incur expenses for *illness* or *injury* that occurred due to the negligence of a third party and benefits are provided for covered services described in this certificate, the *subscriber* agrees:

1. We have the right to reimbursement for all benefits we provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that illness or injury, in the amount of the total eligible charge or health care provider's claim charge for covered services for which we have provided benefits to you, reduced by any average discount percentage ("ADP") applicable to your claim or claims.

2. We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits we provided for that illness or injury.

We shall have the right to first reimbursement out of all funds the *subscriber*, his/her *covered dependents* or the *subscriber*'s legal representative, are or were able to obtain for the same expenses for which we have provided benefits as a result of that *illness* or *injury*.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

F. Subrogation

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits we paid for that *illness* or *injury*. You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

G. Limitation on Lawsuits and Legal Proceedings

By accepting coverage under the Policy, you are agreeing 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 / Definitions); 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 time we require written proof of loss outlined in Section 11. B. (Claim Filing and Processing Procedures / Proof of Loss).

H. Severability

Any term, condition or provision of the Policy that is prohibited by Illinois law will be void and without force or effect. This, however, won't affect the validity and enforceability of any 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.

I. Conformity with Laws and Regulations of the State of Illinois

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.

J. Waiver and Change

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

Any change to the Policy will be made by an endorsement which is 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 may make an equitable adjustment of coverage, payment of *benefits*, and/or premium.

K. Refund Requests

If we pay more *benefits* than what we are 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.

L. Workers' Compensation

The Policy is not issued in lieu of nor, does it affect any requirements for coverage by workers' compensation insurance. *Health care services* for injuries or *illnesses* that are job, employment, or work related, and for which *benefits* are provided or payable under any workers' compensation or occupational disease act or law, are excluded from coverage under the Policy. If a *covered person* receives *benefits* under the Policy for *charges* that are later determined to be eligible under any workers' compensation insurance, workers' compensation act, or employer liability law, the *covered person* will reimburse us in full to the extent that *benefits* were paid by us under the Policy for such *charges*. We reserve the right to recover against you even though:

1. The workers' compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the *illness* or *injury* was sustained in the course of or resulted from employment;

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

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

M. Written Notice

Written notice given by us 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.

N. Initial Claims Determinations

We will usually pay all claims within 30 days of receipt of all information required to process a claim. In the event that we do not process a claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. We will usually notify you, your valid assignee, or your authorized representative when all information required to pay a claim within 30 days of the claim's receipt has not been received. If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim (as defined below). Notification may be oral unless the claimant requests written notification.

O. Time Limit on Certain Defenses

After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such coverage shall be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period

11. CLAIM FILING AND PROCESSING PROCEDURES

A. Definitions

1. **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.

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

3. **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.

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

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

6. **Urgent Claim:** any *pre-service claim* for medical care or *treatment* with respect to which the application of the time periods for making non-*urgent care* determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or in the opinion of a *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.

B. Proof of Loss

1. How to File a Claim

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

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

1) *Subscriber* name;

2) *Subscriber* number;

3) Provider name;

4) Provider address;

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

6) Patient's name;

7) Patient's date of birth;

8) Date of service;

9) Procedure code;

10) Diagnosis code; and

11) Billed *charges* for each service.

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

b. Proof of payment.

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

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

2. Exception to 90-Day Proof of Loss Deadline

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

a. It was not reasonably possible to provide the required information within such time; and

b. The required information is furnished as soon as possible and no later than one year following the initial 90-day period. The only exception to this rule is if you are legally incapacitated. If we do not receive written proof of loss 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 appeal. Please see Section G. (Claim Appeal Procedures) for more information.

C. Designating an *Authorized Representative*

You may designate an *authorized representative* to pursue a claim for *benefits* or an *appeal* 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 *appeal* 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, unless the claim is an *urgent claim* on a form approved by us. 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*.

D. 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 authorized* course of *treatment*. The notice will provide time for you to file an *appeal* and receive a decision on that *appeal* 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 authorized treatment* that involves *urgent care* must be responded to as soon as possible, taking into account medical urgency. We will notify you of the *benefit* determination, whether adverse or not, within 24 hours after receipt of your request provided that the request is submitted to us at least 24 hours prior to the expiration of the prescribed period of time or number of *treatments*.

2. ***Urgent Claims.*** We will notify you of our decision on your claim within 72 hours of receipt of an *urgent claim* or as soon as possible if your condition requires a shorter time frame. You or a health care professional with knowledge of your medical condition may submit the claim to us by telephone, electronic facsimile (i.e. fax) or mail.

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

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

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

3. ***Pre-Service Claims***

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

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

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

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

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

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

E. 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, 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 timeframes 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 *medical 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*.

F. Inquiries and Complaints

An **"**inquiry**"** is a general request for information regarding, claims, benefits or membership.

A **"**complaint**"** is an expression of dissatisfaction by you either orally or in writing.

We have a team available to assist you with inquiries and complaints. Issues may include, but are not limited to the following:

1. Claims; and

2. Quality of care.

When your complaint relates to dissatisfaction with a claim denial (or partial denial), you have the right to a claim review/appeal as described in subsection G. (Claim Appeal Procedures).

To pursue an inquiry or complaint, you may contact our Customer Service Department at the number on the back of your ID card or by calling toll-free (800) 223-6048, or you may write to:

Wisconsin Physicians Service Insurance Corporation
P. O. Box 8190
1717 West Broadway
Madison, Wisconsin 53708-8190
Fax Number: (608) 977-9920

You may also email us: member@wpsic.com.

When you contact Customer Service to pursue an inquiry or complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your inquiry or complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If we need more information, you will be contacted. If a response to your inquiry or complaint will be delayed due to the need for additional information you will be contacted.

G. Claim Appeal Procedures

1. Definitions.

Adverse Benefit Determination: any of the following: a denial, reduction, or termination of, or a failure to provide or make payment 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 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.

In addition, an adverse benefit determination also includes an *adverse determination*.

Adverse Determination: a determination by us or our designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered service has been reviewed and, based upon the information provided, does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated. For purposes of the policy, we will refer to both an adverse determination and an adverse benefit determination as an adverse benefit determination, unless indicated otherwise.

Appeal: an oral or written request for review of an adverse benefit determination or an adverse action by us or a preferred provider. An appeal of an adverse benefit determination may be filed by you or a person authorized to act your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your *authorized representative*.

Final Internal Adverse Benefit Determination: an adverse benefit determination that has been upheld by us at the completion of our internal review/appeal process.

2. Claims Appeal Procedure.

If you have received an *adverse benefit determination*, you may have your claim reviewed on *appeal*. We will review our decision in accordance with the following procedures. The following review procedures will also be used for: (a) coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits; and (b) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals." Under your health plan, there is one level of internal appeal available to you.

Within 180 days after you receive notice of an *adverse benefit determination*, you may call or write to us to request a claim review. We will need to know the reasons why you do not agree with the *adverse benefit determination*. You may call toll-free 1-800-765-4977 or send your request to:

Appeal Committee
Wisconsin Physicians Service Insurance Corporation
P. O. Box 7062
1717 West Broadway
Madison, Wisconsin 53708-7062
Fax Number: (608) 977-9920

You may also email us: member@wpsic.com.

In support of your claim review, you have the option of presenting evidence and testimony to us, by phone or in person at a location of our choice. You and your *authorized representative* may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an *adverse benefit determination* or at any time during the claim review process.

We will provide you or your *authorized representative* with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial *adverse benefit determination*. Such new or additional evidence or rationale and information will be provided to you or your *authorized representative* sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The *appeal* will be conducted by individuals associated with us and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your *authorized representative* may bring any action to recover benefits the claimant must exhaust the *appeal* process and must raise all issues with respect to a claim and must file an *appeal* or *appeals* and the *appeals* must be finally decided by us.

3. Urgent Care/Expedited Clinical Appeals.

If your *appeal* relates to an urgent care/expedited clinical claim, or *health care services*, including, but not limited to, procedures or treatments ordered by a *health care practitioner*, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an

ongoing course of treatment is terminated or reduced, we will provide you with notice and an opportunity to *appeal*. For the ongoing course of treatment, coverage will continue during the *appeal* process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical *appeal*, we will notify the party filing the *appeal*, as soon as possible, but no more than 24 hours after submission of the *appeal*, of all the information needed to review the *appeal*. Additional information must be submitted within 24 hours of request. We shall provide a determination on the *appeal* within 24 hours after it receives the requested information.

4. Other Appeals.

Upon receipt of a non-urgent pre-service or post-service appeal we shall provide a determination of the appeal and notify you or your *authorized representative* within three business days if additional information is needed to review the *appeal*. Additional information must be submitted within five days of the request. We shall provide a determination of the *appeal* within 15 business days after we receive the requested information but in no event more than 30 days after the *appeal* has been received by us.

5. If You Need Assistance.

If you have any questions about the claims procedures or the review procedure, write or call us during normal working hours. If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at, 1-877-527-9431 or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the ILLINOIS DEPARTMENT OF INSURANCE, OFFICE OF CONSUMER HEALTH INFORMATION, a state agency which enforces Illinois' insurance laws, and file a complaint.

You can contact the DEPARTMENT OF INSURANCE using any of the following:

For regular mail, Federal Express, UPS or Overnight Mail:

Springfield Office	**Chicago Office**
Department of Insurance Office of Consumer Health Information Complaints Department 320 West Washington Street, Springfield, IL 62767	Department of Insurance Office of Consumer Health Information Complaints Department 122 South Michigan Avenue, 19th Floor Chicago, IL 60603
By phone: (217) 782-4515 (877) 527-9431 (toll-free within Illinois) TDD (866) 323-5321	(312) 814-2420
Fax numbers: (217) 558-2083	(312) 814-5416

By electronic mail: consumer_complaints@ins.state.il.us.
The on-line complaint forms are located at https://mc.insurance.illinois.gov/messagecenter.nsf.

6. Notice of *Appeal* Determination.

We will notify the party filing the *appeal*, you, and, if a clinical appeal, any *health care practitioner* who recommended the services involved in the *appeal*, orally of its determination followed-up by a written notice of the determination. The written notice will include:

a. the reason for the determination;

b. a reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

c. subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, *health care provider*, claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;

d. an explanation of our external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final decision on external *appeal*;

e. in certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);

f. the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

g. any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

h. an explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and

i. a description of the standard that was used in denying the claim and a discussion of the decision.

If our decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in subsection H. (Independent External Review) below.

If an *appeal* is not resolved to your satisfaction, you may *appeal* our decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify us of the *appeal*. We will have 21 days to respond to the Illinois Department of Insurance.

Our operations are regulated by the Illinois Department of Insurance. Filing an *appeal* does not prevent you from filing a complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a complaint. You may also contact the ILLINOIS DEPARTMENT OF INSURANCE, OFFICE OF CONSUMER HEALTH INFORMATION, a state agency which enforces Illinois' insurance laws, and file a complaint.

You can contact the DEPARTMENT OF INSURANCE using any of the following:

For regular mail, Federal Express, UPS or Overnight Mail:

Springfield Office	**Chicago Office**
Department of Insurance Office of Consumer Health Information Complaints Department 320 West Washington Street, Springfield, IL 62767	Department of Insurance Office of Consumer Health Information Complaints Department 122 South Michigan Avenue, 19th Floor Chicago, IL 60603
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By electronic mail: consumer_complaints@ins.state.il.us.
The on-line complaint forms are located at https://mc.insurance.illinois.gov/messagecenter.nsf.

You must exercise the right to internal *appeal* as a precondition to taking any action against us, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

H. Independent External Review

You or your *authorized representative* may make a request for a standard external or expedited external review of an *adverse determination* or *final adverse determination* by an independent review organization (IRO).

1. Definitions.

a. **Adverse Benefit Determination:** any of the following: a denial, reduction, or termination of, or a failure to provide or make payment 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 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.

b. **Adverse Determination:** a determination by us or our designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered service has been reviewed and, based upon the information provided, does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated.

c. Director: the Director of the Department of Insurance

d. F**inal Adverse Benefit Determination:** an adverse benefit determination that has been upheld by us or our designated utilization review organization at the completion of our internal review/appeal process.

2. Standard External Review.

You or your *authorized representative* must submit to the *Director* a written request for an external independent review within four months of receiving an *adverse determination* or *final adverse determination* using the following contact information:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 (toll-free phone)
(217) 557-8495 (fax number)
Email Address: DOI.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

You may submit additional information or documentation to support your request for the health care services. Within one business day after the date of receipt of a request for external review, the *Director* shall send a copy of the request to us.

a. **Preliminary Review.** Within five business days of receipt of the external review request, we will complete a preliminary review of the request to determine whether:

1) you were covered under the Policy at the time health care service was recommended or requested or, in the case of a retrospective review, at the time the health care service was provided;

2) the recommended or requested health care service or treatment that is the subject of the adverse determination or the final adverse determination is a covered benefit under the policy except for our determination that the health care service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the Policy;

3) we have certified that one of the following situations is applicable:

a) standard health care services or treatments have not been effective in improving your condition;

b) standard health care services or treatments are not medically appropriate for you; or

4) there is no available standard health care service or treatment covered by us that is more beneficial than the recommended or requested health care service or treatment;

5) your *health care provider*:

i. has recommended a health care service that the *health care practitioner* certifies, in writing, is likely to be more beneficial to you, in the *health care practitioner*'s opinion, than any available standard health care services; or

ii. who is a licensed, board certified or board eligible *health care practitioner* qualified to practice in the area of medicine appropriate to treat your condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by you that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to you than any available standard health care services or treatments;

6) you have exhausted our internal appeal process. In certain urgent cases, you may be eligible for expedited external review even if you have not filed an internal appeal with us, and, you may also be eligible for external review if you filed an internal appeal but have not received a decision from us within 15 days after we received all required information, in no case longer than 30 days after you first file the appeal or within 48 hours if you have filed a request for an expedited internal appeal; and

7) you have provided all the information and forms required to process an external review.

b. Notification. Within one business day after completion of the preliminary review, we shall notify the Director, you and your *authorized representative*, if applicable, in writing whether the request is complete and eligible for an external review.

If the request is not complete or not eligible for an external review, you shall be notified by us in writing of what materials are required to make the request complete or the reason for its ineligibility. Our determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director. The Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of the Policy and shall be subject to all applicable laws.

If a request for external review is determined eligible for external review, we shall notify the Director and you and, if applicable, your *authorized representative*.

c. Assignment of IRO. Whenever the Director receives notice that a request is eligible for external review following the preliminary review described above, within one business day after the date of receipt of the notice, the Director shall: (1) assign an independent review organization from the list of approved independent review organizations and notify us of the name of the assigned independent review organization; and (2) notify in writing you and, if applicable, your *authorized representative*, of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to you and, if applicable, your *authorized representative* a statement that you or your *authorized representative* may, within five business days following the date of receipt of the notice, submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when

conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

Upon the Director's assignment of an IRO, we or our designated utilization review organization shall, within five business days, provide to the assigned IRO the documents and any information considered in making the adverse determination or final adverse determination. In addition, you or your *authorized representative* may, within five business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after five business days. If we or our designated utilization review organization does not provide the documents and information within five business days, the IRO may end the external review and make a decision to reverse the adverse determination or final adverse determination. A failure by us or our designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the external review. Within one business day after making the decision to end the external review, the IRO shall notify WPS, you and, if applicable, your *authorized representative*, of its decision to reverse the determination.

If you or your *authorized representative* submitted additional information to the IRO, the IRO shall forward the additional information to us within one business day of receipt from you or your *authorized representative*. Upon receipt of such information, we may reconsider the adverse determination or final adverse determination. Such reconsideration shall not delay the external review. We may end the external review and make a decision to reverse the adverse determination or final adverse determination. Within one business day after making the decision to end the external review, we shall notify the IRO, you, and if applicable, your *authorized representative* of its decision to reverse the determination.

d. **IRO's Decision.** In addition to the documents and information provided by WPS and you, or if applicable, your *authorized representative*, the IRO shall also consider the following information if available and appropriate:

1) your medical records;

2) your health care provider's recommendation;

3) consulting reports from appropriate health care providers and associated records from health care providers;

4) the terms of coverage under the policy;

5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

6) any applicable clinical review criteria developed and used by us or our designated utilization review organization;

The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above, for a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether and to what extent (a) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, (b) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment would be substantially increased over those of available standard health care services or treatments, or (c) the terms of coverage under the Policy to ensure that the health care services or treatment would otherwise be covered under the terms of coverage of the Policy.

Within 5 days after the date of receipt of the necessary information, but in no event more than 45 days, the IRO will render its decision to uphold or reverse the adverse determination or final adverse determination. The IRO is not bound by any claim determinations reached prior to the submission of information to the IRO. You and your *authorized representative*, if applicable, will receive written notice from the IRO. The written notice will include:

1) a general description of the reason for the request for external review;

2) the date the IRO received the assignment from the Director;

3) the time period during which the external review was conducted;

4) references to the evidence or documentation including the evidence-based standards, considered in reaching its decision;

5) the date of its decisions,

6) the principal reason or reasons for its decision, including, what applicable, if any, evidence-based standards that were a basis for its decisions; and

7) the rationale for its decision.

If the external review was a review of experimental or investigational treatments, the notice shall include the following additional information:

1) a description of your medical condition;

2) a description of the indicators relevant to whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to you than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatments would not be substantially increased over those of available standard health care services or treatments;

3) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

4) a description and analysis of any evidence-based standards;

5) whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration;

6) whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to you than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

7) The written opinion of the clinical reviewer, including the reviewer's recommendations or requested health care service or treatment that should be covered and the rationale for the reviewer's recommendation.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, we shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the Policy even if the IRO determines that the health care services being reviewed were medically appropriate.

3. Expedited External Review.

If you have a medical condition where the timeframe for completion of: (a) an expedited internal review of an appeal involving an adverse determination; (b) a final adverse determination as set forth in the Illinois Managed Care Reform and Patient Rights Act; or, (c) a standard external review as set forth in the Illinois Health Care External Review Act, would seriously jeopardize your life or health or your ability to regain maximum function, then you have the right to have the adverse determination or final adverse determination reviewed by an IRO not associated with us. In addition, if a final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, then you may request an expedited external review.

You may also request an expedited external review if the treatment or service in question has been denied on the basis that it is considered experimental or investigational and your health care provider certifies in writing that the treatment or service would be significantly less effective if not started promptly.

Your request for an expedited independent external review may be submitted orally or in writing.

a. **Notification.** We shall immediately notify you and your *authorized representative*, if applicable, in writing whether the expedited request is complete and eligible for an expedited external review. Our determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director. The Director may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the Director's decision shall be in accordance with the terms of the Policy and shall be subject to all applicable laws.

b. **Assignment of IRO.** If your request is eligible for expedited external review, the Director shall immediately assign an IRO from the list of approved IROs and notify us of the name of the assigned IRO.

Upon assignment of an IRO, we or our designated utilization review organization shall, within 24 hours provide to the assigned IRO the documents and any information considered in making the adverse determination or final adverse determination. In addition, you or your *authorized representative* may submit additional information in writing to the assigned IRO. If we or our designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the adverse determination or final adverse determination. Within 1 business day after making the decision to end the external review, the IRO shall notify us, you and, if applicable your *authorized representative*, of its decision to reverse the determination.

Within 2 business days after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the adverse determination or final adverse determination and you will receive notification from us. The assigned IRO is not bound by any decisions or conclusions reached during our utilization review process or our internal appeal process. Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, we shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the Policy if the IRO determines that the health care services being appealed were medically appropriate.

Within 48 hours after the date of providing the notice, the assigned IRO shall provide written confirmation of the decision to you, us and, if applicable, your *authorized representative*, including all the information outlined under the standard process above.

An external review decision is binding on us. An external review decision is binding on you, except to the extent you have other remedies available under applicable federal or state law. You and your *authorized representative* may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which you have already received an external review decision.

I. Notice of Claim

Written notice of claim must be given to WPS within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on your behalf to WPS at its Madison office, or to any authorized agent of WPS, with information sufficient to identify you, shall be deemed notice to WPS.

J. Claim Forms

WPS will, upon receipt of a notice of claim, furnish to the covered person such forms as are usually furnished by us for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the covered person shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, shall be deemed notice to us.

K. Physical Examinations and Autopsy

WPS at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

12. DEFINITIONS

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

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

1. Bathing which is the cleansing of the body in either a tub or shower or by sponge bath;
2. Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
3. Toileting which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
4. Mobility, which is to move from one place to another, with or without assistance of equipment;
5. Eating, which is getting nourishment into the body by any means other than intravenous; and
6. Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

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

Authorized Representative: a person designated to file a claim for *benefits* or an *appeal* 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 *mental illness 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.

Calendar Year: the period of time that starts with your applicable effective date of coverage shown in our records 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.

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

Child/Children: any of the following:

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

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

7. The *child* of a *subscriber's civil union spouse*.

Civil Union: a legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

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

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.

Congenital Anomaly: a physical developmental defect that is present at the time of birth, and that is identified within the first 12 months of birth.

Congenital or Genetic Disorder: a disorder that includes, but is not limited to, hereditary disorders, Congenital or genetic disorders may also include, but are not limited to, autism or an *autism spectrum disorder*, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

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

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

Correctly Filed Claim: a claim that includes: (1) the completed claim forms that we require; (2) the actual itemized bill for each *health care service*; and (3) all other information that we need to determine our liability to pay *benefits* under the Policy, including but not limited to, medical records and reports.

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

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

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

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

Custodial Care: services that are any of the following:

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

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

1. You are under the care of a *health care practitioner*;
2. The *health care practitioner* prescribes *health care services* to support and maintain your physical and/or mental condition;
3. Services are being provided by a nurse; or
4. Such care involves the use of technical medical skills if such skills can be easily taught to a layperson.

Deductible: the specified amount you are required to pay for *covered expenses* in a *calendar year* before *benefits* are payable under the Policy. This defined term does not include a *specialty drug deductible* as defined in Section 5. PP. (Covered Expenses / Prescription Legend Drugs and Supplies).

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.

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).

Developmental Disability: a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all of the following conditions:

1. it is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
2. it is manifested before the individual reaches age 22;
3. it is likely to continue indefinitely; and
4. it results in substantial functional limitations in three or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, and capacity for independent living.

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

1. The person must be in a committed relationship (relationship of mutual support, caring and commitment and intend to remain in such a relationship in the immediate future) with the *subscriber*;
2. Each partner must be 18 years of age or older;
3. Neither partner is married or legally separated in marriage, and must not have been a party to an action or proceeding for divorce or annulment within six months of registration, or, if one has been married, at least six months have lapsed since the date of the judgment terminating the marriage;
4. Each partner must be competent to contract;
5. Neither partner is currently registered in another domestic partnership, and if either party has been in such a registered relationship, at least six months have lapsed since the effective date of termination of that registered relationship;
6. There are no blood ties between the *subscriber* and his/her partner closer than that permitted for marriage or for one to qualify for *domestic partner* registration;
7. The relationship of the *subscriber* and his/her *domestic partner* must not be merely temporary, social, political, commercial or economic in nature (i.e., there must be mutual financial interdependency); and
8. The *subscriber* must register his/her partner as a *domestic partner* with his/her employer and WPS by providing proof that, for at least the six-month period immediately preceding the date of registration, the *subscriber* either had obtained

a domestic partnership certificate from the city, county or state of residence or from any other city, county or state offering the ability to register a domestic partnership or has any three of the following with respect to the partner**:**

a. joint lease, mortgage or deed;

b. joint ownership of a vehicle;

c. joint ownership of checking account (demand deposit) or credit account;

d. designation of the partner as a beneficiary of the *subscriber's* will;

e. designation of the partner as a beneficiary for the *subscriber's* life insurance or retirement benefits;

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

g. shared household expenses.

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

Early Acquired Disorder: a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self−help skills. Early acquired disorder may include, but is not limited to, autism or an *autism spectrum disorder* and cerebral palsy.

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

1. A *subscriber's* legal *spouse* by marriage or *civil union*.

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

3. A *subscriber's child* who is a military veteran and is under the age of 30, provided he/she: (a.) is an Illinois resident; (b) is not married; (c) served in the active or reserve components of the U.S. Armed Forces; and (d) has received a release or discharge other than a dishonorable discharge.

4. A subscriber's *child* over age 26 (or 30 for military veterans) if the following criteria are met:

a. the *child* must not be able to hold a self-sustaining job;

b. be principally supported by the *subscriber* or dependent on other care providers for lifetime care and supervision. "Dependent or other care providers" means requiring a Community Integrated Living Arrangement, group home, supervised apartment or other residential services licensed or certified by the Department of Mental Health and Developmental Disabilities, the Department of Public Health or the Department of Public Aid;

c. the *child's* incapacity existed before he/she reached the limiting age; and

d. the *subscriber's family coverage* remains in force under the Policy.

e. Written proof of the *child's* totally disabling condition must be given to us within 31 days of the child attaining the limiting age. Failure to provide such proof within that 31-day period shall result in the termination of that *dependent child*'s coverage. Proof of incapacity may be requested annually after the two-year period immediately following attainment of the limiting age by the *child*.

5. If shown in the *policyholder's* current application for coverage as being applicable, a *subscriber's domestic partner*.

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

Emergency Medical Care: *health care services* provided by a *health care provider* to treat your *medical emergency*

Emergency Room Visit: a meeting between you and a *health care practitioner* that: (1) occurs at the emergency room; and (2) includes only the *charges* for the emergency room fee billed by the facility for use of the emergency room.

Experimental/Investigational/Unproven: any *health care service* or facility that meets at least one of the following criteria:

1. It is not currently recognized as accepted medical practice;
2. It was not recognized as accepted medical practice at the time the *charges* were incurred;
3. It has not been approved by the United States Food and Drug Administration (FDA) upon completion of Phase III clinical investigation;
4. It is being used in a way that is not approved by the FDA or listed in the FDA-approved labeling (*i.e.* off-label use), except for off-label uses that are accepted medical practice);
5. It has not successfully completed all phases of clinical trials, unless required by law;
6. It is based upon or similar to a treatment protocol used in on-going clinical trials;
7. Prevailing peer-reviewed medical literature in the United States has failed to demonstrate that it is safe and effective for your condition;
8. There is not enough scientific evidence to demonstrate or make a convincing argument that (a) it can measure or alter the sought-after changes to your *illness* or *injury* or (b) such measurement or alteration will affect your health outcome; or support conclusions concerning the effect of the drug, device, procedure, service or *treatment* on health outcomes.
9. It is associated with a Category III CPT code developed by the American Medical Association.

The above list is not all-inclusive.

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

We may determine whether a *health care service* is *experimental/investigational/unproven*. 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.

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*.

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.

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

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

Geographical Service Area: the region in which WPS operates and your *plan* is available. Please see wpshealth.com for more information.

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.WW. (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* acting within the lawful scope of his/her/its license.

High-Technology Imaging: including, but not limited to: magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), single photon emission computed tomography (SPECT), computed tomography (CT) imaging, and nuclear stress testing for high-end imaging.

Hospital: a facility providing 24-hour continuous service to a *confined covered person*. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, *treatment* and care of injured or sick persons. A professional staff of licensed *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 medical conditions. A *hospital* does not include: (1) a convalescent or extended care facility unit within or affiliated with the *hospital*; (2) a clinic; (3) a nursing, rest or convalescent home; (4) a skilled nursing facility; (5) a facility operated mainly for care of the aged; (6) sub-acute care center; or (7) a health resort, spa or sanitarium.

Illness: a *physical illness*, a *substance use disorder*, or *mental illness disorder*.

Injury: bodily damage caused by an accident. The bodily damage must result from the accident independent of disease or infirmity.

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

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

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

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

1. A description of our specific methodology, including, but not limited to, the following:
    - **a.** the source of the data used, such as our claims experience, an expert panel of *health care providers*, or other sources;
    - **b.** the frequency of updating such data; and
    - **c.** the geographic area used.

2. The *maximum allowable fee* based on our guidelines for a specific *health care service* provided to you. That may be in the form of a range of payments or maximum payment.

Maximum Out-of-Network Allowable Fee: the *benefit* limit established by us for a covered *health care service* provided by a *non-preferred provider*. The *benefit* limit for a particular *health care service* is based on a percentage of the published rate allowed for Illinois by the Centers for Medicare and Medicaid Services (CMS) for the same or similar *health care service*.

The baseline for the maximum out-of-network allowable fee is based on the Wisconsin geographic area. A variety of percentages are utilized, based on the service category, and vary from 130% up to 325% of the Medicare allowable amounts. The Medicare allowable amounts are evaluated on a semiannual basis to validate the rates that have been established.

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*.

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 to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

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

Medically Necessary: a *health care service* that is:

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

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

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

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

Mental Illness Disorder(s): disorders that are clinically significant psychological syndromes associated with distress, dysfunction or physical illness. The syndrome must represent a dysfunctional response to a situation or event that exposes you to an increased risk of pain, suffering, conflict, physical illness or death. A *mental illness disorder* does not include behavior problems, learning disabilities, autism or *developmental delays*. *Mental illness disorder* shall include a *serious mental illness*.

Miscellaneous Hospital Expense: regular *hospital* costs (including take-home drug expenses) that we cover under the Policy for *treatment* of an *illness* or *injury* requiring either: (1) inpatient hospitalization; or (2) outpatient *health care*

services at a *hospital*. For outpatient *health care services*, *miscellaneous hospital expenses* include *charges* for: (1) use of the *hospital's* emergency room; and (2) *emergency medical care* provided to you at the *hospital*. *Miscellaneous hospital expenses* do not include room and board, nursing services, and *ambulance services*.

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.

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

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

Office Visit: either of the following:

1. For *health care services* other than *behavioral health services*, a meeting between you and a *health care provider* that: (a) occurs at the *health care provider's* office, a medical clinic, *convenient care clinic*, an ambulatory surgical center, a free-standing *urgent care* center, *skilled nursing facility*, or the outpatient department of a *hospital*, other than an emergency room, or in your home; and (b) includes you receiving medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology) or manipulations by a *health care practitioner*, other than services related to physical therapy.

2. For *behavioral health services*, a meeting between you and a *health care practitioner* licensed to provide nonresidential services for the *treatment* of *mental illness disorders* and/or *substance use disorders* that: (a) occurs in the *health care practitioner's* office, a medical clinic, a free-standing *urgent care* center, *skilled nursing facility*, outpatient *treatment* facility, the outpatient department of a *hospital*, other than an emergency room, or in your home; and (b) includes you receiving psychotherapy, psychiatric diagnostic interviews, medication management, electro-shock therapy, behavioral counseling, or neuropsychological testing.

Out-of-pocket Limit: the maximum amount that you are required to pay each *calendar year* for *covered expenses*. This limit is shown in the Schedule of Benefits. Any of the following costs will count towards your *out-of-pocket limit*: (1) the *deductible*; (2) *copayments*; and (3) *coinsurance* amounts you pay for *covered expenses* associated with *health care services*. In determining whether you've reached your *out-of-pocket limit*, the following amounts will not count: (1) amounts you pay for non-covered *health care services*; and (2) amounts you pay that exceed the *maximum allowable fee*.

Partial Hospitalization Treatment Program: a program of a hospital or *substance use disorder* treatment facility for the treatment of *mental illness disorders* or *substance use disorder.*

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 *mental illness disorders*.

Physician: a person who:

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

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

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

Placed for Adoption/Placement for Adoption: when a child who is in the custody of the *subscriber*, pursuant to an interim court order of adoption or, placement of adoption, whichever comes first, vesting temporary care of the child in the subscriber, is an adopted child, regardless of whether a final order granting adoption is ultimately issued.

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

Preferred Provider: a *health care provider* that has entered into a written agreement with the *health care provider* network shown on your WPS identification card as of the date upon which the services are provided. The Preferred Provider Directory is available online at wpshealth.com or by request from WPS. 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*.

Primary Care Practitioner: a *preferred 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.

Private Duty Nursing Service: skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Private duty nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private duty nursing service does not include custodial care.

Reconstructive Surgery: surgery performed on abnormal structures of the body caused by: (1) congenital defects; (2) development abnormalities; (3) trauma; (4) infection; (5) tumors; or (6) disease.

Rescission: coverage termination due to a *covered person's* performing an act or practice which constitutes fraud or who makes an intentional misrepresentation of material fact as prohibited by the terms of this Policy. This does not include a cancellation or discontinuance of coverage due to failure to timely pay the required premiums or contributions towards the cost of the coverage.

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

Serious Mental Illness: the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

1. Schizophrenia;

2. Paranoid and other psychotic disorders;

3. Bipolar disorders (hypomanic, manic, depressive, and mixed);

4. Major depressive disorders (single episode or recurrent);

5. Schizo-affective disorders (bipolar or depressive);

6. Pervasive developmental disorders;

7. Obsessive-compulsive disorders;

8. Depression in childhood and adolescence;

9. Panic disorder;

10. Post-traumatic stress disorders (acute, chronic, or with delayed onset); and

11. Anorexia nervosa and bulimia nervosa.

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

Skilled Nursing Care: *health care services* that: (1) are furnished pursuant to a *health care practitioner's* orders; (2) require the skills of professional personnel such as a registered nurse or a licensed practical nurse; and (3) are provided either directly by or under the direct supervision of such professional personnel. Patients receiving *skilled nursing care* are usually quite ill and often have been recently hospitalized. 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 *spouse*s, *children,* or other family or relatives. The following examples are generally considered care that can be provided by "nonskilled" persons, and therefore do not qualify as *skilled nursing care*: range of motion exercises, strengthening exercises, simple wound care, ostomy care, tube and gastrostomy feedings, administration of basic medications, maintenance of urinary catheters, assistance with performing *activities of daily living*, and supervision for potentially unsafe behavior.

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

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

Skilled Nursing Service: those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for skilled nursing service will not be provided due to the lack of willing or available non-professional personnel. Skilled nursing service does not include custodial care.

Specialty Health Care Practitioner: a *preferred provider* so 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.

Spouse: legal spouse by marriage or *civil union*.

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

Substance Use Disorder(s): the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a behavioral health practitioner. This includes the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

1. substance abuse disorders;
2. substance dependence disorders; and
3. substance induced disorders.

Supplies: *medical supplies*, *durable medical equipment* or other supplies provided directly to you by a *health care provider*.

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

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

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

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