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. (General Provisions / 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
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1. GENERAL INFORMATION

A. General Description of Coverage

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

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

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

B. Entire Contract

The entire contract between you and us is made up of the Group Master Policy, the policyholder’s group application, any supplemental policyholder applications, this Certificate, the Schedule of Benefits, any endorsements, your application, and any supplemental applications. These documents are collectively referred to as the “Policy.” No change in this policy shall be valid until approved by an executive officer of the company and unless the approval is added by endorsement or attached to the Policy. No agent has authority to change this Policy or to waive any of its provisions.

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 Policy benefits, and check your deductible.

E. Your Choice of Health Care Providers Affects Your Benefits

Preferred providers are health care providers who are part of our network as shown on your WPS identification card. See Section 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. (Covered Expenses / Alternative Care). The fact that we provide such coverage in one case will not require us to do so in any other case, regardless of any similarities between the two.

We 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 Subsection E. (Special Enrollment Periods) below for more information about these special enrollment opportunities.

C. Initial Enrollment Period

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

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

D. Annual 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.

E. Special Enrollment Periods

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

Except as noted below, we generally must receive an application from the eligible employee listing all individuals he/she wants to enroll within 31 days after the eligible employee or eligible dependent experiences the special late enrollment circumstance (e.g., birth, marriage, loss of coverage). If we do not receive the application 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 application within 60 days after they are determined to be eligible for the subsidy.

2) Loss of Other Health Care Coverage

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

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

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

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

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

1) Loss of eligibility;

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

3) COBRA continuation coverage ended;

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

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

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

7) The eligible employee and/or eligible dependent loses eligibility for Medicaid, including 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 application within 31 days after the loss of other health care coverage. If health care coverage is lost for the reason outlined in Paragraph 2) c) 7) (loss of eligibility for Medicaid), coverage for the eligible employee and/or his/her eligible dependents under the Policy will begin on the first day following the date the eligible employee’s or eligible dependent’s other health coverage ended if we receive an application within 60 days after the loss of other health care coverage. Otherwise, the eligible employee and/or eligible dependents may not be added until the next annual 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 application within 31 days after the date of marriage or civil union, the eligible spouse’s coverage will be effective on the date of marriage or civil union. Otherwise, the spouse may not be added until the next annual open enrollment period.

4) Birth of a Child

Coverage is provided for a newborn biological child who meets the definition of eligible dependent from the moment of that child’s birth and for the next 60 days of that child’s life immediately following that child’s date of birth. If coverage is needed to continue after the 60 days, you must add the child.

To add a newborn biological child, you must submit an application 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 application 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 or Foster Care

If a subscriber wishes to obtain coverage for a child, because of his/her adoption of a child or a child was placed for adoption or foster care with him/her, an application listing the child(ren) must be received by the policyholder within 31 days after the date of the adoption, placement for adoption or placement in foster care. The effective date for coverage will be one of the following: (a) 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.

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

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 application and affidavit. If we receive an application and affidavit 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 any of the following:

1) A preferred provider

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

D. Our Utilization Management Program

Utilization management (UM) is the evaluation of whether a health care service is medically necessary. Our UM program is designed to ensure that you are receiving high-quality medical care that is both appropriate and cost effective. You will receive benefits under the Policy only when health care services are determined to be medically necessary.
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

We will provide at least 60 days notice of nonrenewal or termination of a preferred provider.

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 https://www.wpshealth.com/resources/files/provider-prior-authorization.pdf

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 treatment*)

Examples of potential *cosmetic treatment*:

1. Blepharoplasty, canthoplasty, eyelid, or eyebrow surgery
2. Panniculectomy
3. Pectus excavatum/carinatum
4. Port wine stain laser treatment
5. Reduction/augmentation mammoplasty/mastopexy and related services (Services related to breast reconstruction following mastectomy do not require prior authorization)
6. Rhinoplasty
7. Temporomandibular joint disease (TMJ)
8. Orthognathic surgical services
9. Varicose vein treatment
10. Laser treatment for psoriasis

l) Cranial orthotic
m) Deep brain stimulation (DBS)

n) **Durable medical equipment** (DME):

1. Rental above $750 per month or purchase above $1,000 threshold
2. All CPAP/BiPAP rentals and purchases require authorization
3. Alternative communications and speech generating devices
4. Crutch substitutes
5. Hospital beds
6. Power wheelchairs, custom built wheelchairs, and scooters
7. Home UVB light treatment of skin conditions
8. 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) Intravenous immunoglobulin (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:
   1. Epidural steroid injections
(2) Facet joint injections (includes facet, MBB, zygapophysial joint, paravertebral facet joint, and dorsal/posterior ramus injections)
(3) Intrathecal pump implantation
(4) Lumbar discography
(5) Radiofrequency ablation
(6) Spinal cord/dorsal column stimulation
(7) Automated percutaneous lumbar discectomy
(8) 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:
   (1) Polysomnograms (sleep study: home and in-lab)
   (2) CPAP/BiPAP machines
   (3) Oral appliances
   (4) Surgical procedures (e.g., 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)

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 https://www.wpshealth.com/resources/files/drugpreauth.pdf. 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) 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 we determine that the health care service would have been covered under the Policy if you had followed the prior authorization process, we will reprocess the affected claim(s) in accordance with your standard benefits.

9) **What Health Care Services Do Not Require a Prior Authorization?** You do not need a prior authorization from us or any other person 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. (Covered Expenses / Prescription Legend Drugs and Supplies) for information about prescription copayments.

If you receive health care services other than emergency room care at a hospital-based outpatient clinic or location, your bill may show two separate charges – one for the health care practitioner and one for the facility. The copayment only applies to the charge billed by the health care practitioner. Facility charges are subject to the applicable annual deductible and coinsurance amounts of the Policy. See Section 5. S. (Covered Expenses / 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. F. (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 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 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*;
   c) When *ambulance services* are provided by anyone other than a licensed *ambulance service*; or
   d) When *ambulance services* are called, but you are not transported (please note that any *emergency medical care* provided to you will be payable under Section 5. S. (Emergency Medicare Care).

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 Paragraph 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) *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

1) 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 disorders 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


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 I. does not apply to surgery performed for removal of breast implants that were implanted solely for cosmetic reasons except for when due to association with Anaplastic Large Cell Lymphoma. 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

*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
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) **Covered Dental Services:**
   a) Dental repair or replacement of your 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
(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;
   (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.

2) 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 1) above.
   c) Any surgical procedure, except as stated in Paragraph 1) above or specifically stated in Section 5. WW. (Surgical Services).
   d) Tooth extraction of any kind, except as specifically stated in Paragraph 1) above.
   e) Periodontal care.

P. Diabetes Treatment

1) 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 provider 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.

2) 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).

3) 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)

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, 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; 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 Paragraph 3) 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) 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 testing.
   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;
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) 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.

2) 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) 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.

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

2) Home Care Limitations:

a) 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.

3) 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) 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.

2) 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. (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.

      (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 limited to:

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

      (2) Radiation therapy treatments

      (3) Chemotherapy.
(4) Electroconvulsive therapy

(4) Electroconvulsive therapy

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

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

e) **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.

2) **Hospital Services Limitations:**

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

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

**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) **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) Charges 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.

2) **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.

3) **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 *covered 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;

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 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) Home births.

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

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

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).

J.J. 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

b) 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) **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 Limitation:** Benefits will be limited to the standard models.

3) **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*.

**OO. Palliative Care Services**

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

**PP. 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.

**QQ. Prescription Legend Drugs and Supplies**

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

1) **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

l) Self-injectable medications

m) Topical anti-inflammatory drugs including, Ketoprofen, Diclofenac, and other prescription legend drugs that are approved by the FDA for acute and chronic pain.

2) Covered Supplies:

a) Insulin syringes and needles.

b) Lancets and lancet devices.

c) Formulary diabetic test strips.

d) Alcohol pads.

e) Formulary blood glucose monitors.

f) Auto injector.

g) Glucose control solution.

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

4) Cost Sharing. See your Schedule of Benefits for information about copayments, deductibles, and coinsurance amounts that apply to drugs and supplies. You will have no applicable copayment, deductible, or coinsurance, for (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.

5) 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). Prescription legend drugs for the treatment of stage 4 advanced, metastatic cancer are not subject to these step therapy requirements as long as the use of the prescription legend drug is consistent with best practices and is supported by peer-reviewed medical literature.

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

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

f) **Quantity Limits.** The following quantity limits apply to all prescription legend drug benefits under this Subsection. 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.
<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription legend drugs or supplies dispensed by a preferred pharmacy</td>
<td>Up to a 30-90 day supply per fill or refill</td>
</tr>
<tr>
<td>Prescription legend drugs (other than specialty drugs) or supplies dispensed by a home delivery pharmacy</td>
<td>Up to a 90-day supply per fill or refill</td>
</tr>
<tr>
<td>Preventive drugs used for Tobacco Cessation</td>
<td>180-day supply of nicotine replacement treatment (e.g., patches or gum) per covered person per 365-day period; and 180-day supply of another type of covered tobacco cessation drug (e.g., varenicline or bupropion) per covered person per 365-day period</td>
</tr>
<tr>
<td>Specialty drugs and biosimilar drugs</td>
<td>Up to a 30-day supply per fill or refill, except as noted above</td>
</tr>
<tr>
<td>Blood glucose monitor dispensed by a preferred pharmacy</td>
<td>One per covered person per calendar year</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>12-month supply</td>
</tr>
<tr>
<td>Short-term opioid prescriptions for acute pain</td>
<td>Up to a 7-day supply</td>
</tr>
</tbody>
</table>

**g) 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).

**6) 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.

7) 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:

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

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

c) The medications are not Schedule II, III, or IV controlled substances;

d) The covered person meets all utilization management criteria specific to the prescription drugs at the time of synchronization;

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

f) 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.

8) Opioid Use Disorder. Benefits for Buprenorphine products or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder do not require prior authorization, or have dispensing limits, fail first policies, or lifetime limits.

Benefits will be provided for at least one intranasal opioid reversal agent prescription for initial prescriptions of opioids with dosages of 50 MME or higher.
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) Administration of a covered drug by injection or other means other than covered immunizations.

c) Refills of otherwise covered drugs which exceed the number your prescription order calls for.

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

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

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

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

h) Costs related to the mailing, sending or delivery of prescription legend drugs.

i) Prescription or refill of drugs, medicines, medications or supplies that are lost, stolen, spoiled, damaged, or otherwise rendered unusable.

j) Any drug or medicine that is available in prescription strength without a prescription.

k) 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.

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

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

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

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

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

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

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

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

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

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

v) Any drug in unit-dose packaging except as required by law.

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

**RR. Preventive Care Services**

The following preventive care services are covered to the extent required by law. There is no cost sharing on preventive care services performed by a preferred provider.
1) **Covered Preventive Care Services 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.
7. BRCA risk assessments and genetic counseling/testing.
8. Breast cancer preventive medications.
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.
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.
(45) Sterilization procedures.

b) Route 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.

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

2) **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.
      (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.
(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.
(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.
i) Screening for urinary incontinence.

5) Preventive Care Services Limitation: Some office visits and 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, office visits and laboratory and diagnostic services 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).

SS. 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.

TT. 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.

UU. 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.

VV. 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.

WW. 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 (Hearing Aids, Implantable Hearing Devices and Related Treatment), 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.

XX. 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. (Pain Management Treatment), Section 5. AAA. (Transplants), and Section 5. UU. (Reconstructive Procedures) for this coverage information.

1) Covered Surgical Services: The following surgical services are covered when provided in a health care practitioner’s office, hospital or licensed surgical center:
   a) Surgical services, other than reconstructive surgery and oral surgery. Covered surgical services include but are not limited to:
      (1) Operative and cutting procedures;
      (2) 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, 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

(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; and

(5) Orthognathic procedures.

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.

e) Bariatric surgery.

f) Removal of breast implants due to association with Anaplastic Large Cell Lymphoma.

2) 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).

f) Transoral incisionless fundoplication procedures.

YY. Telemedicine

1) 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.

2) 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) Transmission fees.

b) Website charges for online patient education material.

ZZ. Temporomandibular Joint (TMJ) Disorder Services

1) Covered TMJ Services:

a) Diagnostic procedures, surgical services and non-surgical treatment for the correction of TMJ disorders if all of the following apply:
(1) The disorder is caused by congenital, developmental or acquired deformity, illness or injury;
(2) Under the accepted standards of the profession of the health care practitioner providing the service; 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.

AAA. Therapy Services

1) Covered Therapy Services:

a) Outpatient therapy is limited as follows:

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

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

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

(4) Multiple sclerosis preventative physical therapy.

The limits stated in (1), (2), and (3) above do not apply to Section 5. D. (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.

2) 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 YY. (Temporomandibular (TMJ) Disorder Services).

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

c) 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.
BBB. Transplants

1) Prior Authorization and Cost-Sharing Requirements:
   a) All transplant services require prior authorization. It is your responsibility to obtain a prior authorization for all transplant related services, including but not limited to the initial transplant evaluation. The transplant must meet our 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 services are subject to any deductibles, coinsurance, maximum or limits shown in the Schedule of Benefits.

2) Covered Transplants:
   a) We will cover approved transplant services, including but not limited to organ and tissue acquisition and transplantation, including any post-transplant complications, if you are the recipient; and related medical care, including any post-harvesting complication, if you are a donor.
   b) Covered expenses for transplant services include health care services for approved transplants when ordered by a physician. Health care services include, but are not limited to, hospital charges, physician charges, organ and tissue acquisition, tissue typing, and ancillary services. Covered transplant drugs are payable as described in Section 5. 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
     12) Artificial or mechanical devices, if approved as a bridge to transplant or destination therapy

3) 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.

4) 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 2). 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 Paragraph 3. 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.

CCC. 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.

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.

DDD. Vision Services – Pediatric

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

a) Routine eye exams, including refractions.

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

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. Confinement 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 confinement 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) Confinement in 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) Confinement in 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 confinement or other services and supplies that are not medically necessary.

We will make the decision whether confinement 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 CONFINED 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 confinement or other health care services and supplies as medically necessary does not make the confinement, services or supplies medically necessary and does not mean that we will pay the cost of the confinement, 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 CONFINEMENT OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, WE WILL NOT PAY FOR THE CONFINEMENT, 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.

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. SS. (Covered Expenses / 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. BBB. (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. (Covered Expenses / Alternative Care).

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

25) **Health care services** not provided by a **health care practitioner** or any of the **health care providers** listed in Section 5. (Covered Expenses).
26) The following procedures and any related health care services:
   a) Injection of filling material (collagen) other than for incontinence;
   b) Salabrasion;
   c) Rhytidectomy (face lift);
   d) Dermabrasion;
   e) Chemical peel;
   f) Suction-assisted lipectomy (liposuction);
   g) Hair removal;
   h) Mastopexy;
   i) Augmentation mammoplasty (except for reconstruction associated with a covered mastectomy);
   j) Correction of inverted nipples;
   k) Sclerotherapy or other treatment for varicose veins less than 3.5 millimeters in size (e.g. telangiectasias, spider veins, reticular veins);
   l) Excision or elimination of hanging skin on any part of the body, such as panniculectomy; abdominoplasty and brachioplasty;
   m) Mastectomy for 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 services and surgical services for the treatment of excessive sweating (hyperhidrosis).

27) Health care services provided at any nursing facility or convalescent home or charges billed by any place that'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. (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 weavng, 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).


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. (Covered Expenses / 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 c) (Dependent Child/Separated or Divorced Parents) below, when the Policy and another plan cover the same child as a dependent of different persons, called “parents”, the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year, but if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

   However, if the other plan does not have the rules described above but instead has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
   c) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      (1) First, the plan of the parent with custody of the child;
      (2) Then, the plan of the spouse or domestic partner of the parent with custody of the child; and
      (3) Finally, the plan of the parent not having custody of the child.

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

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

d) **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, Paragraph 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 Paragraph b) (Dependent Child/Parents Not Separated or Divorced) to the dependent child's parent or parents and the dependent's spouse.

e) **Active/Inactive Employee.** The benefits of a plan which covers a person as an employee who is neither laid-off nor retired or as that employee's dependent are determined before those of a plan which covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this Paragraph e. 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 e).

f) **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 Ssubparagraph (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) The last day of the applicable grace period if the premium required for your coverage has not been paid to us in accordance with the Policy.

4) The date you enter into military service, other than for an assignment of less than 30 days.
5) The last day of the calendar month in which the subscriber’s employment terminates.

6) The last day of the calendar month in which we 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;

   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, or for a military veteran age 30.

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

B. Special Rules for 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 proof of disability annually.
It is the subscriber’s responsibility to notify the policyholder if his/her child no longer qualifies as an eligible dependent. If he/she does not so notify the policyholder, 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. 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 Subsection 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;

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 dependents. 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, you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent claim). 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. 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
      (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. Prescription legend drug claims made after 4:00 PM will be logged in and handled on the next business day.
4) **How to Appeal a Claim Denial.** If a claim is denied, you may *Appeal* the denial by filing a written *Appeal*. Please see Section G. (Claim Appeal Procedures) for more information.

**B. 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*.

**C. Claim Processing Procedure:**

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

1) **Concurrent Care Decisions.** We will notify you of a *concurrent care decision* that involves a reduction in or termination of *benefits* prior to the end of any *prior authorization* for a course of *treatment*. The notice will provide time for you to file 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 authorization* of *treatment* that involves *urgent care* must be responded to as soon as possible, taking into account medical urgency. We will notify you of the *benefit* determination, whether adverse or not, within 24 hours after receipt of your request provided that the request is submitted to us at least 24 hours prior to the expiration of the prescribed period of time or number of *treatments*.

2) **Urgent Claims.** We will notify you of our decision on your claim within 72 hours of receipt of an *urgent claim* or as soon as possible if your condition requires a shorter time frame. You or a health care professional with knowledge of your medical condition may submit the claim to us by telephone, electronic facsimile (i.e. fax) or mail.

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

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

If the claim is an *incomplete claim*, we will notify you of the specific information needed as soon as possible, but no later than 48 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 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 30-day period. For example, if our notification was sent to you on the fifth day of the first 30-day period, we would have a total of 40 days to make a decision on your claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 90 days from the date we received the post-service claim.

D. Claim Decisions

If benefits are payable on charges for services covered under the Policy, we will pay such benefits directly to the health care provider providing such services, unless you advise us in writing prior to payment that you have already paid the charges and submitted paid receipts. We will send you written notice of the benefits we paid on your behalf. If you have already paid the charges and are seeking reimbursement from us, payment of such benefits will be made directly to you.

If the claim is denied, 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.

E. 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 F. (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.

F. Claim Appeal Procedures

1) 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.

2) Urgent Care/Expedited Clinical Appeals. If your appeal relates to an urgent 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.

3) 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.

4) 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:

<table>
<thead>
<tr>
<th>Springfield Office</th>
<th>Chicago Office</th>
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<tbody>
<tr>
<td><strong>Department of Insurance</strong></td>
<td><strong>Department of Insurance</strong></td>
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<tr>
<td><strong>Office of Consumer Health Information</strong></td>
<td><strong>Office of Consumer Health Information</strong></td>
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<tr>
<td><strong>Complaints Department</strong></td>
<td><strong>Complaints Department</strong></td>
</tr>
<tr>
<td>320 West Washington Street</td>
<td>122 South Michigan Avenue, 19th Floor</td>
</tr>
<tr>
<td>Springfield, IL 62767</td>
<td>Chicago, IL 60603</td>
</tr>
<tr>
<td>Phone: (217) 782-4515</td>
<td>Phone: (312) 814-2420</td>
</tr>
<tr>
<td>(877) 527-9431 (toll free within Illinois)</td>
<td></td>
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<tr>
<td>TDD: (866) 323-5321</td>
<td></td>
</tr>
<tr>
<td>Fax: (217) 558-2083</td>
<td>Fax: (312) 814-5416</td>
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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.

5) **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 upon 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 12. (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:

<table>
<thead>
<tr>
<th>Springfield Office</th>
<th>Chicago Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Insurance</td>
<td>Department of Insurance</td>
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<tr>
<td>Office of Consumer Health Information</td>
<td>Office of Consumer Health Information</td>
</tr>
<tr>
<td>Complaints Department</td>
<td>Complaints Department</td>
</tr>
<tr>
<td>320 West Washington Street</td>
<td>122 South Michigan Avenue, 19th Floor</td>
</tr>
<tr>
<td>Phone: (217) 782-4515</td>
<td>Phone: (312) 814-2420</td>
</tr>
<tr>
<td>(877) 527-9431 (toll free within Illinois)</td>
<td></td>
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<tr>
<td>TDD: (866) 323-5321</td>
<td></td>
</tr>
<tr>
<td>Fax: (217) 558-2083</td>
<td>Fax: (312) 814-5416</td>
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</tbody>
</table>

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.

G. 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) 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

(c) 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*;

(4) Your *health care provider*:

(a) 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

(b) 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; and
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.

2) 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.

**H. 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.

**I. 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.

**J. 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.

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.

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.

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.

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.

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.

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

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.

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.

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.

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.

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.

**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.

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

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

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

**Category B Devices:** As determined by the FDA, 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.

**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 solely under the subscriber’s (or his/her spouse’s) court-ordered legal guardianship, as determined by us.
5) A child who is considered an alternate recipient under a qualified medical child support order. See Section 2. E. 6) (Eligibility, Enrollment, and Effective Date / Special Enrollment Periods) 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.
8) A child placed in foster care with a subscriber.

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.

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.

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

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

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

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

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.

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.

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 services benefits (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

3) 24-hour supervision for potentially unsafe behavior.
4) Supervision of medication which usually can be self-administered.

5) Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

1) You are under the care of a health care practitioner;

2) The health care practitioner prescribes health care services to support and maintain your physical and/or mental condition;

3) Services are being provided by a nurse; or

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

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.

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.

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.

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.

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.

Director: the Director of the Department of Insurance

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.

Donor: an oocyte donor or sperm donor.

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 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.

6) A child, under the age of 26, for whom the subscriber (or his/her spouse) was the legal guardian prior to the child turning 18 years of age.

Eligible Employee: a person who is either (1) employed by the policyholder on a permanent, full-time basis (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.

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

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

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.

**Final 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.

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

**Functional Impairment**: a significant and documented loss of use of any body structure or body function that results in a person's inability to regularly perform one or more activity of daily living or to use transportation, shop, or handle finances.

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

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

Genetic testing includes, but is not limited to: (1) gene expression and determination of gene function (genomics); (2) analysis of genetic variations; (3) multiple gene panels; (4) genetic 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 Policy is available. Please see wpshealth.com for more information.

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

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

**Health Care Provider**: any physician, health care practitioner, hospital, pharmacy, clinic, skilled nursing facility, surgical center or other person, institution or other entity licensed by the state in which he/she/it is located to provide health care services.
Health Care Services: diagnosis, treatment, hospital services, surgical services as defined in Section 5.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.

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

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.

High-Technology Imaging: including, but not limited to: magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), single photon emission computed tomography (SPECT), computed tomography (CT) imaging, and nuclear stress testing for high-end imaging.

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

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

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

Hospice Care: health care services that are: a) provided to a covered person whose life expectancy, as certified by a health care practitioner, is 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.

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.

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

Illness: a physical illness, a substance use disorder, or a mental illness disorder.

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

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

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

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

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.

Injury: bodily damage caused by an accident. The bodily damage must result from the accident independent of disease or infirmity.

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.

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.

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.

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

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

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.
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.

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 Nutrition Therapy: shall have the meaning ascribed to “medical nutrition care” in the Dietetic and Nutrition Services Practice Act.

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) confinement in a hospital; 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.

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

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

Non-Designated Transplant Facility: a facility that does not have an agreement with the transplant provider network with which we have a contract. This may include facilities that are listed as preferred providers. Non-designated transplant facilities are shown in the Schedule of Benefits as non-preferred providers.
Non-Preferred Provider: a health care provider that has not entered into a written agreement with the health care network selected by the policyholder or covered person.

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.

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

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.

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.

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.

Oral Surgery: surgical services performed within the oral cavity.

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

Out-of-Pocket Limit: the maximum amount that you are required to pay each calendar year for covered expenses. This limit is shown in the Schedule of Benefits. Any of the following costs will count towards your out-of-pocket limit: (1) 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.

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.

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.

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

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

Placed for Adoption/Placement for Adoption: 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.

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

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

Preferred Drugs(s): any generic drug or brand-name drug named on our formulary for which member cost-sharing is lower than for a non-preferred-drug. The drugs designated as preferred drugs on our formulary may change from time to time.

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

Preferred Provider: a health care provider that has entered into a written agreement with the 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.

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.

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

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

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 preclampsia; (2) fluoride supplements if you are older than six months but younger than 17 years old; (3) folic acid for women planning or capable of pregnancy; (4) oral contraceptives, contraceptive patches, contraceptive devices (e.g., diaphragms, sponges 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) risk reducing medications, such as tamoxifen or raloxifene, for women who are at increased risk for breast cancer and at low risk for adverse medication effects; (7) immunizations; (8) low/moderate dose statins for ages 40-75 with at least one cardiovascular disease risk factor and a 10-year calculated cardiovascular risk of at least 10%; and (9) bowel preparations related to a preventive colonoscopy. The USPSTF may change the definition of preventive drugs during the course of the year. Please see https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

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.
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.

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:
   2) National Institutes of Health (NIH), including the National Cancer Institute (NCI).
   3) Centers for Disease Control and Prevention (CDC).
   4) Agency for Healthcare Research and Quality (AHRQ).
   5) Centers for Medicare and Medicaid Services (CMS).
   6) A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
   7) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   8) The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
      a) Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
      b) Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   9) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   10) 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.

Reconstructive Surgery: surgery performed on abnormal structures of the body caused by: (1) congenital defects; (2) development abnormalities; (3) trauma; (4) infection; (5) tumors; or (6) disease.

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

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.

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

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

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) Schizoaffective 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)
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 confined in a hospital. In the majority of cases, skilled nursing care is only
necessary for a limited time period. After that, most patients have recuperated enough to be cared for by “nonskilled” persons such as spouses, children, or other family or relatives. The following examples are generally considered care that can be provided by “nonskilled” persons, and therefore do not qualify as skilled nursing care: range of motion exercises, strengthening exercises, simple wound care, ostomy care, tube and gastrostomy feedings, administration of basic medications, maintenance of urinary catheters, assistance with performing activities of daily living, and supervision for potentially unsafe behavior.

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

1) Is operating pursuant to state and federal law;
2) Is under the full-time supervision of a health care practitioner or registered nurse;
3) 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 care 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 Drugs:** prescription legend drugs that 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 wsphealth.com or call the telephone number shown on your identification card.

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

**Specialty Health Care Practitioner:** a preferred provider 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.

**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.

**Spouse:** legal spouse by marriage or civil union.

**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.

**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
3) Substance induced disorders

**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.

**Substance Use Disorder Treatment Facility**: a facility (other than a hospital) whose primary function is the treatment of substance use disorders 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.

**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.

**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.

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

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

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

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

**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.

**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.

**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;

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 above, “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.

**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.

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

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

1) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

2) In the opinion of a *health care practitioner* with actual knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or *treatment* that is the subject of the claim.

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

**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.

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

**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.