



Short Term Insurance Policy

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

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

Your Right to Return This Policy. Please read this Policy right away. If you're not satisfied with this Policy for any reason, you may return it by notifying us in writing or by calling the number shown on your identification card within 10 days after you receive your new member materials. If you notify us within that 10-day period, we will cancel your coverage under this Policy and refund all premium payments that you've made to us for it. The Policy will become null and void and no coverage will be provided to you under it.

This Policy (the "Policy") includes a Schedule of Benefits. It may also include one or several endorsements. **Please read all of these documents carefully so you know and understand your coverage.**

This Policy is not renewable. This Policy is in effect only for the *coverage period* described below and shown in your completed application for coverage. This Policy terminates automatically without notice at the end of this *coverage period*, unless terminated earlier as stated in Section VIII. (When Coverage Ends).

Coverage Period: This policy is in effect from the effective date through the termination date indicated on your application, unless terminated earlier in accordance with Section VIII. (When Coverage Ends). Benefits are not payable for expenses incurred for health care services directly provided to you before your effective date of coverage or after the end of your coverage under this Policy. Please see Exclusion A. in Section VI. (General Exclusions). Your coverage under this Policy will never continue after this policy's termination date.

Pre-existing illness or injury is not covered. This Policy will only pay benefits for an illness manifesting itself after your effective date of coverage under this policy or for an injury occurring after such effective date. Benefits are not payable for expenses incurred for health care services for any pre-existing illnesses or injuries or any complications of any such illnesses or injuries. See the definition of *pre-existing illness* or *injury* in Section 0. (Definitions) and Exclusion C. in Section VI. (General Exclusions).

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of your completed application attached to your Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the insurer within 10 days if any information shown on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance policy. The insurance policy was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations

regarding coverage of pre-existing conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

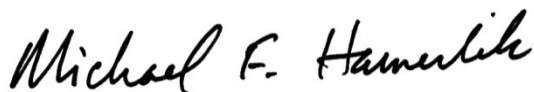
Unless otherwise stated, Wisconsin Physicians Service Insurance Corporation (hereinafter “WPS”, “we”, “our”, or “us”) will not pay for most *health care services* under the Policy until you have paid certain out-of-pocket amounts, called annual *deductibles*. Please see the Schedule of Benefits to determine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

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

The amount we pay for a covered *health care service* will always be limited to the *maximum allowable fee*, as defined in Section 0. (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 Policy is issued by WPS and delivered to the *subscriber* in Wisconsin. All terms, conditions, and provisions of this Policy, including, but not limited to, all exclusions and coverage limitations contained in the Policy, are governed by the laws of Wisconsin. All *benefits* are provided in accordance with the terms, conditions, and provisions of the Policy, any endorsements attached to this Policy, 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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I. GENERAL INFORMATION

A. General Description of Coverage

This Policy is part of the contract between WPS and the *subscriber* named on the WPS identification card. In return for the subscriber's premium payments and each *covered person's* compliance with all of the terms, conditions and provisions of this Policy you are entitled to receive the benefits described in this Policy.

This Policy 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*.

B. Effective Date

After the applicant applies for coverage, we will review his/her application and determine whether those named on the application are eligible for coverage. This Policy will only be issued to the persons named on the application for whom we approve for coverage. Once coverage is issued, the effective date of this Policy will be the effective date stated in your completed application for coverage, as determined by us.

C. Entire Contract

The entire contract between you and us is made up of this Policy, the Schedule of Benefits, any endorsements, your completed application, and any supplemental applications.

D. How to Use This Policy

You should read this Policy, including its Schedule of Benefits and all endorsements, carefully and completely. The provisions of this Policy 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 Policy has a special meaning, which is explained in Section XIV. (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 Policy, the terms "you" and "your" refer to any *covered person*. The terms "we", "us", and "our" refer to WPS.

E. How to Get More Information

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

F. 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 XIV. (Definitions) for more information.

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

Non-preferred providers are *health care providers* who have not agreed to participate in the health care network shown on your WPS identification card.

If you use a *non-preferred provider*, covered *charges* will be payable under this Policy up to *the maximum out-of-network allowable fee* as defined in Section XIV. (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.

G. Covered Expenses

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

In certain circumstances for purposes of overall cost savings or efficiency, we have full discretionary authority to pay *benefits* for *health care services*: (1) at the *preferred provider* level of benefits for a *health care service* provided by a *non-preferred provider*; or (2) that are not covered under the Policy, to the limited extent provided in Section V. 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 have full discretionary authority to arrange for other persons or entities to provide administrative services related to the Policy, including claims processing and utilization management without notice to you. We also have full discretionary authority to authorize other persons or entities to exercise discretionary authority with regard to the Policy without notice to you. By accepting this Policy, you agree to cooperate fully with those persons or entities in the performance of their responsibilities.

II. SPECIAL ENROLLMENT PERIODS

A special enrollment period is available for birth, adoption or placement for adoption, or child support or other court order.

A. Birth of a Child

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

If a *subscriber* has *single coverage*, coverage is provided for a newborn biological *child* who meets the definition of *eligible dependent* from the moment of that *child's* birth and for the next 60 days of that *child's* life immediately following that *child's* date of birth. If a *subscriber* wishes to change to *family coverage* to add his/her newborn biological *child* and any other *eligible dependent(s)*, we must receive an application, listing all *eligible dependent(s)* for whom the *subscriber* wishes coverage, within the first 60 days after the birth of his/her biological *child*.

To add a newborn biological *child*, you must submit an application and pay any required premium within 60 days after the date of birth. If you fail to notify us and do not make any required payment beyond the 60-day period, coverage will end, unless you make all past due payments with 5.5% interest, within one year of the *child's* birth. In this case, *benefits* are retroactive to the date of birth. If we do not receive the application within one year after the *child's* birth, the newborn may not be added.

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

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

If a *subscriber* has *single coverage* and wishes to change to *family coverage* because of his/her adoption of a *child* or a *child* was *placed for adoption*, we must receive an application listing the *eligible dependent(s)* the *subscriber* wants to enroll within 60 days after the date of the adoption, *placement for adoption*. If we receive the application after the 60-day enrollment period ends, the *eligible dependent(s)* may not be added.

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

C. Court Order

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

In order to obtain coverage, the *subscriber*, the *child's* other parent, the Wisconsin Department of Children and Families, or the county child support agency under Wis. Stat. § 59.53(5) must submit the following to us after the applicable court order is issued: (a) a completed application listing all *eligible dependents* the *subscriber* wishes to cover; (b) a copy of the court order; and (c) payment for the appropriate premium.

The effective date of *family coverage* under this Subsection E. will be either the date that court order is issued; or another coverage date contained in that court order. Such coverage will continue in effect until the earliest of the following dates:

1. The date upon which the *subscriber* is no longer eligible for *family coverage* under the Policy;
2. The date upon which the court order expires;
3. The date upon which the *child* obtains coverage under another group policy or individual policy that provides comparable health care coverage, as applicable; or
4. The date upon which the *child's* coverage ends sooner in accordance with Section VIII. (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 health care coverage is becoming effective for that child.

III. OBTAINING SERVICES

A. Prior Authorization

1. **What is Prior Authorization?** *Prior authorization* is the process we use to determine if a prescribed *health care service*, including certain *prescription legend drugs*, is covered under the Policy before you receive it. This process is intended to protect you from unnecessary, ineffective, and unsafe services and to prevent you from becoming responsible for a large bill for *health care services* or *prescription legend drugs* that are not covered by the Policy.
2. **When Do I Have to Obtain Prior Authorization?** You are required to obtain *prior authorization* before you visit certain *health care providers* or receive certain *health care services*, such as planned inpatient admissions, pain management, spinal surgery, new technologies (which may be considered *experimental/investigational/unproven*), non-emergency ambulance services, high-cost *durable medical equipment*, *genetic testing*, *prescription legend drugs*, or procedures that could potentially be considered *cosmetic treatment*. A current list of *health care providers* and *health care services* for which *prior authorization* is required is located on our website at <https://wpshealth.com/resources/provider-resources/provider-news/2015-prior-auth.shtml>. Please refer to this website often, as we have full discretionary authority to change it from time to time without notice to you.
3. **How do I Request Prior Authorization?**
 - a. *Health Care Services Other Than Prescription Legend Drugs:* Ask your *health care practitioner* to contact our Customer Service Department by calling the telephone number shown on your identification card or to download, complete, and submit the printable Prior Authorization Form on our website. You should then call Customer Service to verify that we have received the *prior authorization* request. Please note that for genetic services, we will not accept *prior authorization* requests from the laboratory that will perform the genetic services unless there is supporting documentation from the ordering *health care provider*.

- b. *Prescription Legend Drugs: Prescription legend drugs that require prior authorization are noted on our website at wpshealth.com. Your health care practitioner should contact us or our delegate, as indicated, to initiate the process. To find out about the prior authorization process for prescription legend drugs, see Section V. Z. (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 Sections XI. (Claim Filing and Processing Procedures) and XII. (Internal Grievance and Appeals Procedures) for additional details.
5. **What Are My Responsibilities During the Prior Authorization Process?** Although your *health care provider* should initiate the *prior authorization* process, it is your responsibility to ensure that we have approved the *prior authorization* request before you obtain the applicable *health care services*.
6. **My Prior Authorization Request Was Approved – Now What?** If we, or our *delegate*, approve your request, our *prior authorization* will only be valid for: (a) the *covered person* for whom the *prior authorization* was made; (b) the *health care services* specified in the *prior authorization* and approved by us; and (c) the specific period of time and service location approved by us.

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

7. **My Prior Authorization Request Was Denied – Now What?** If we disapprove your request for a *health care service*, you can request that we review and reconsider the denial of *benefits* by following the procedures outlined in Section XI. (Claim Filing and Processing Procedures) and XII. (Internal Grievance and Appeals Procedures). If you chose to receive *health care services* after receiving our *prior authorization* denial, such services will not be covered.
8. **What Happens If I Do Not Obtain a Prior Authorization?** Failure to comply with our *prior authorization* requirements will initially result in no *benefits* being paid under the Policy. If, however, *benefits* are denied solely because you did not obtain our *prior authorization*, you can request that we review and reconsider the denial of *benefits* by following the procedures outlined in Sections XI. (Claim Filing and Processing Procedures) and XII. (Internal Grievance and Appeals Procedures). If you prove to us that the *health care service* would have been covered under the Policy if you had followed the *prior authorization* process, we will reprocess the affected claim(s) in accordance with your standard *benefits*.
9. **What Health Care Services Do Not Require a Prior Authorization?** You do not need a *prior authorization* from us or any other person (including your *PCP*) to obtain *emergency medical care* or *urgent care* at an emergency or *urgent care* facility.

B. Coding Errors

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

C. Our Utilization Management Program

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

We will make the final determination of whether any service is *medically necessary* or subject to a pre-existing exclusion. If you choose to receive a *health care service* that we determine is not *medically necessary*, you will be responsible for paying all *charges* and no *benefits* will be paid under the Policy.

D. Continuity of Care

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

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

IV. PAYMENT OF BENEFITS

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

A. Deductible

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

When your *deductible* is satisfied, *charges* for *covered expenses* will still be subject to any *copayment* and/or *coinsurance* amounts shown in your Schedule of Benefits.

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

You also have a separate *drug deductible* when you get a prescription filled. See Section V. Z. (Covered Expenses / Prescription Legend Drugs and Supplies) for information about the prescription *drug deductible*.

B. Coinsurance

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

C. Copayments

Your *copayments* are set forth in your Schedule of Benefits.

If you receive *health care services* at a *hospital-based* outpatient clinic or location, you may be billed two separate *charges* – one for the *health care practitioner* and one for the facility. The *copayment* only applies to the *charge* billed by the *health care practitioner*. Facility *charges* are subject to the applicable *deductible* and *coinsurance* amounts of the Policy.

D. Out-of-Pocket Limits

You are required to pay your applicable *cost sharing* up to the *out-of-pocket limit* shown in your Schedule of Benefits. When your *out-of-pocket limit* is satisfied, *cost sharing* will not apply and we will pay *benefits* up to the *maximum allowable fee* for covered *health care services* you receive during the remainder of the *coverage period*, 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.

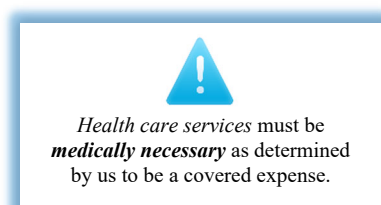
E. Maximum Benefit Limit.

The maximum benefit limit is the total amount of *benefits* payable for covered *illnesses* and *injuries* for each *covered person* during the *coverage period* excluding covered drugs and supplies as stated in Section V. Z. (Covered Expenses / Prescription Legend Drugs and Supplies). No *benefits* are payable for expenses incurred for *health care services* directly provided to you either before your *coverage period* effective date or after your coverage has terminated. Please see Section VIII. (When Coverage Ends) and Exclusion. in Section VI. (General Exclusions). In no event will we pay more than the maximum benefit limit in any *coverage period*.

F. Maximum Allowable Fee

We'll pay *charges* for the *covered expenses* described in Section V. (Covered Expenses) up to the *maximum allowable fee* subject to your *cost sharing* as described above. If you receive *health care services* from a *non-preferred provider*, you are solely responsible for paying any *charge* that exceeds the *maximum out-of-network allowable fee*. Regardless of what *health care provider* you see, you are also solely responsible for paying any *charge* for a *health care service* that we do not cover under the Policy.

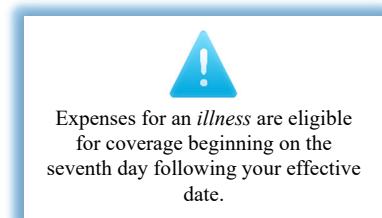
You may contact us before receiving a *health care service* to determine if the *health care provider's* estimated *charge* is less than or equal to the *maximum allowable fee*. In order for us to make this determination you will need to provide us with the following information: (1) the estimated amount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



V. COVERED EXPENSES

Health care services described in this Section V. 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 V. and Section VI.

(General Exclusions). Expenses for an *injury* are eligible for coverage as of your policy effective date. Expenses for an *illness* are eligible for coverage beginning on the seventh day following your effective date. If a *health care service* is not listed in this Section V., 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 III. A. (Obtaining Services / Prior Authorization) for detailed information about our *prior authorizations*.

Additionally, all *benefits* are subject to the *cost sharing* amounts, *out-of-pocket limits* and all other provisions stated in the Schedule of Benefits. See Section IV. (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 have full discretionary authority to consider paying for such non-covered *health care services* and we may consider an alternative care plan if we find that:

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

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

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

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. Between a *hospital* and *specialty care practitioner* whose *treatment* is for a *life-threatening condition*;
 - e. From a *skilled nursing facility* to a dialysis facility, and from the dialysis facility back to the *skilled nursing facility*; or
 - f. Between a *skilled nursing facility* and a *specialty care practitioner* whose *treatment* is for a *life-threatening condition*.
2. Your *ambulance services benefits* include coverage of any *emergency medical care* directly provided to you during your ambulance transport. In other words, if the *ambulance service* bills *emergency medical care* along with transport services, *benefits* are payable as stated in this Subsection D. If, however, the *ambulance service* bills *emergency medical care* separate from the transport services, *benefits* will be payable as stated elsewhere in the applicable provisions of the Policy.
3. *Ambulance services* for emergency transports must be made to the closest local facility or *preferred provider* that can provide *health care services* appropriate for your *illness* or *injury*, as determined by us. If none of these facilities are located in your local area, you are covered for transports to the closest facility outside your local area.
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*.



Non-emergency transports may require *prior authorization*.
See wpshealth.com.

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

This Section V. E. (Covered Expenses / Autism Services) is not subject to the exclusions in Section VI. (General Exclusions). The only exclusions that apply to this Section are outlined below in Paragraph 2 below (Autism Services Exclusions), except for durable medical equipment and prescription legend drugs. Please see Sections V. N. (Covered Expenses / Durable Medical Equipment) and V. Z. (Covered Expenses / Prescription Legend Drugs and Supplies).

1. Covered Autism Services:

- a. **Diagnostic testing.** The testing tools used must be appropriate to the presenting characteristics and age of the covered person and empirically valid for diagnosing autism spectrum disorders consistent with the criteria provided in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. We reserve the right to require a second opinion with a provider mutually agreeable to the covered person and us.
- b. **Intensive-level services.** We will provide up to four years of intensive-level services that commence after you are two years of age and before you are nine years of age. The majority of the services must be provided to you when your parent or legal guardian is present and engaged. While receiving intensive-level services, you must be directly observed by the qualified provider at least once every two months. In addition, the intensive-level services must be all of the following:
 - 1) Evidence-based.
 - 2) Provided by a qualified provider, professional, therapist, or paraprofessional, as those terms are defined by state law.
 - 3) Based on a treatment plan developed by a qualified provider or professional as defined by state law that includes an average of 20 or more hours per week over a six-month period with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that you be present and engaged in the intervention.
 - 4) Provided in an environment most conducive to achieving the goals of your treatment plan.
 - 5) Assessed and documented throughout the course of treatment. We may request and review your treatment plan and the summary of progress on a periodic basis.
 - 6) Designed to include training and consultation, participation in team meetings and active involvement of the covered person's family and *treatment* team for implementation of the therapeutic goals developed by the team.
- c. **Concomitant services by a qualified therapist.** We will cover services by a qualified therapist when all the following are true:
 - 1) The services are provided concomitant with intensive-level evidence-based behavioral therapy;
 - 2) You have a primary diagnosis of an autism spectrum disorder;

- 3) You are actively receiving behavioral services from a qualified intensive-level provider or qualified intensive-level professional; and
 - 4) The qualified therapist develops and implements a treatment plan consistent with their license and this Section V. E. (Covered Expenses / Autism Services)
- d. Non-intensive-level services.** You are eligible for non-intensive-level services, including direct or consultative services, that are evidence-based and are provided by a qualified provider, supervising provider, professional, therapist or paraprofessional under one of the following scenarios: (1) after the completion of intensive-level services, as long as the non-intensive-level services are designed to sustain and maximize gains made during the intensive-level *treatment*; or (2) if you have not and will not receive intensive-level services but non-intensive-level services will improve your condition. Non-intensive-level services must be all of the following:
- 1) Based upon a treatment plan and include specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that you be present and engaged in the intervention.
 - 2) Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law.
 - 3) Provided in an environment most conducive to achieving the goals of your treatment plan.
 - 4) Designed to provide training and consultation, participation in team meetings and active involvement of the covered person's family in order to implement therapeutic goals developed by the team.
 - 5) Designed to provide supervision for qualified professionals and paraprofessionals in the treatment team.
 - 6) Assessed and documented throughout the course of treatment. We may request and review your treatment plan and the summary of progress on a periodic basis.

Benefits are payable up to the maximum benefit limits stated in the Schedule of Benefits.

2. Autism Services Exclusions:

This Section V. E. is only subject to the following exclusions. The Policy provides no *benefits* for:

- a. Acupuncture;
- b. Animal-based therapy including hippotherapy;
- c. Auditory integration training;
- d. Chelation therapy;
- e. *Child* care fees;
- f. Cranial sacral therapy;
- g. Hyperbaric oxygen therapy;
- h. Custodial care or respite care;
- i. Special diets or supplements;
- j. Provider travel expenses;
- k. Therapy, *treatment* or services when provided to a *covered person* who is residing in a residential treatment center, inpatient treatment or day treatment facility;
- l. Costs for the facility or location or for the use of a facility or location when *treatment*, therapy or services are provided outside of your home;
- m. Claims that have been determined by us to be fraudulent; and

- n. *Treatment* provided by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessionals for *treatment* provided to their own *children*.

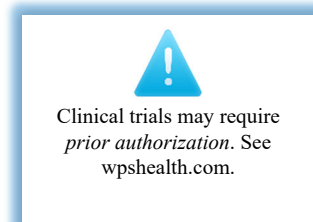
F. Blood and Blood Plasma

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

G. Cancer Clinical Trials

- 1. **Definitions.** The following definitions apply to this Section V. G. only:

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



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

- 1) Used within the context of an FDA-approved clinical trial;
 - 2) Used according to the clinical trial's approved protocols;
 - 3) Fall under a covered benefit category and not excluded by law, regulation or current Medicare coverage guidelines;
 - 4) *Medically necessary* for the *covered person*, and the amount, duration and frequency of use or application of the service is medically appropriate; and
 - 5) Furnished in a setting appropriate to the *covered person's* medical needs and condition.
- b. **Qualifying Clinical Trial:** with respect to cancer, 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 which meets any of the criteria in the bulleted list below.
 - 1) Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - a) National Institutes of Health (NIH), including the National Cancer Institute (NCI).
 - b) Centers for Disease Control and Prevention (CDC).
 - c) Agency for Healthcare Research and Quality (AHRQ).
 - d) Centers for Medicare and Medicaid Services (CMS).
 - e) A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
 - f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g) The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
 - i. Comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

- ii. Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- 2) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
- 3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

c. Routine Patient Care Costs:

- 1) Include costs associated with any of the following:
 - a) *Health care services* that are typically covered under the Policy absent a clinical trial;
 - b) Covered *health care services* required solely for the provision of the trial *health care service* and clinically appropriate monitoring of the effects of the *health care service* trial;
 - c) Reasonable and necessary *health care services* used to diagnose and treat complications arising from your participation in a *qualifying clinical trial*; and
 - d) Covered *health care services* needed for reasonable and necessary care arising from the provision of a trial *health care service*.
- 2) Do not include costs associated with:
 - a) *Experimental/investigational/unproven health care services* with the exception of:
 - i. *Category B devices*;
 - ii. Certain promising interventions for patients with terminal *illnesses*; and
 - iii. Other *health care services* that meet specified criteria in accordance with our medical policy guidelines.
 - b) *Health care services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient*;
 - c) *Health care services* provided by the research sponsors at no *charge* to any person enrolled in the trial; or
 - d) *Health care services* that are clearly inconsistent with widely accepted and established *standards of care* for a particular diagnosis.

2. Benefits.

Routine patient care costs that you incur while participating in a *qualifying clinical trial* for the *treatment of cancer*. *Benefits* are available only when you are eligible to participate in a *qualifying clinical trial* according to the trial protocol.

H. Cardiac Rehabilitation Services

1. Covered Cardiac Rehabilitation Services:

- a. Phase I cardiac rehabilitation sessions while you are confined as an inpatient in a hospital;

- b. Up to 36 supervised and monitored Phase II cardiac rehabilitation sessions per covered *illness* while you are an outpatient receiving services in a facility with a facility-approved cardiac rehabilitation program.

2. Cardiac Rehabilitation Exclusions:

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

- a. Cardiac rehabilitation beyond Phase II.
- b. Behavioral or vocational counseling.

I. Chiropractic Services

For therapy *benefits*, please see Section V. HH. (Covered Expenses / Therapy Services).

1. Covered Chiropractic Services:

Medically necessary services and diagnostic tests provided by a chiropractor.

2. Chiropractic Services Exclusion:

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

J. Contraceptives for Birth Control

1. Covered Contraceptives for Birth Control:

FDA-approved contraceptive methods which require a prescription or intervention by a *health care practitioner*, including related *health care services*. Examples of devices, medications, and *health care services* covered under this Policy include:

- a. Intrauterine devices (IUDs) and subdermal implants; and
- b. Contraceptive injections.

Please note that oral contraceptives, contraceptive patches, diaphragms and contraceptive vaginal rings are covered under Section V. Z. (Covered Expenses / Prescription Legend Drugs and Supplies).

2. Contraceptives for Birth Control Exclusion:

The Policy provides no *benefits* for contraceptive devices or supplies which can be obtained without intervention by a *health care practitioner* including, but not limited to, condoms and contraceptive foam or gel. This exclusion applies in addition to the exclusions outlined in Section VI. (General Exclusions).

K. Dental Services

For *oral surgery benefits* including oral reconstructive maxillofacial surgery, please see Section V. FF. (Covered Expenses / Surgical Services).

1. Covered Dental Services:

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

- a. You are a *child* under the age of five;
- b. You have a chronic disability that meets all of the following:
 - 1) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
 - 2) Is likely to continue indefinitely; and

- 3) Results in substantial limitations as determined by us in one or more of the following areas: self-care, receptive and expressive language, learning, mobility, capacity for independent living, and economic self-sufficiency; or
- c. You have a medical condition that requires hospitalization or a medical condition that requires general anesthesia for dental care.

2. Dental Services Exclusions:

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

- a. The general dental care and *treatment* of teeth, gums, or alveolar process including dentures, appliances, or *supplies* used in such care or *treatment*.
- b. *Injury* or damage to teeth (natural or otherwise) caused by chewing food or similar substances.
- c. Dental implants or other implant-related procedures.
- d. Orthodontic *treatment* (e.g. braces).
- e. Tooth extraction.
- f. Periodontal care.

L. Diabetes Services

For insulin, drugs and *supplies* used in the treatment of diabetes, please see Section V. Z. (Prescription Legend Drugs and Supplies).

1. Covered Diabetes Services:

- a. Purchase and installation of up to one insulin infusion pump per *covered person* per *coverage period*.
- b. Continuous glucose monitor.
- c. All other equipment and *supplies* used in the *treatment* of diabetes when they are dispensed by a *health care provider* other than a pharmacy.
- d. Nutritional counseling provided by a *health care practitioner*, dietician or nutritionist licensed in the state where the counseling is provided to you.
- e. Diabetic self-management education programs.

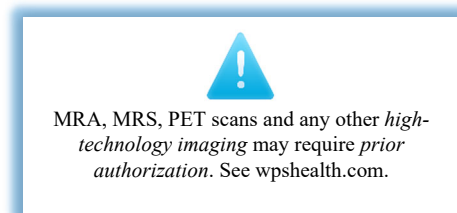
- 2. **Diabetes Services Exclusion:** The Policy provides no *benefit* for the replacement of equipment unless *medically necessary* as determined by us. This exclusion applies in addition to the exclusions outlined in Section VI. (General Exclusions).

M. Diagnostic Services

1. Covered Diagnostic Services:

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

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



2. Diagnostic Services Exclusions:

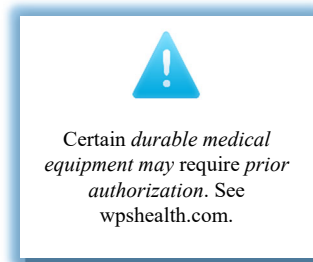
The Policy provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section VI. (General Exclusions).

- a. *Charges* for computer-aided detection (except for screening mammogram interpretation).
- b. *Charges* for imaging studies not for purposes of diagnosis (e.g. assisting in the design or manufacture of individualized orthopedic implants or computer assisted navigation).

N. Durable Medical Equipment

1. Covered Durable Medical Equipment:

- a. Rental or, at our option, purchase of *durable medical equipment* that is prescribed by a *health care practitioner* and needed in the *treatment* of an *illness* or *injury*.
- b. Subsequent repairs necessary to restore purchased *durable medical equipment* to a serviceable condition.
- c. Replacement of *durable medical equipment* if such equipment cannot be restored to a serviceable condition or if warranty has expired, subject to approval by us.



2. Durable Medical Equipment Limitations:

- a. *Benefits* will be limited to the standard models, as determined by us.
- b. If the *durable medical equipment* is purchased, *benefits* are limited to a single purchase of each type (including repair and replacement)
- c. We will pay *benefits* for only one of the following: a manual wheelchair, a motorized wheelchair, a knee walker, or a motorized scooter, as determined by us.

3. Durable Medical Equipment Exclusions:

- a. The Policy provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section VI. (General Exclusions).
- b. Rental fees that are more than the purchase price.
- c. Continuous passive motion (CPM) devices and mechanical stretching devices.
- d. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; home pneumatic compression devices for DVT (deep vein thrombosis) prevention; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs, and cryotherapy; and home automated external defibrillator (AED).
- e. *Durable medical equipment* that we determine to have special features that are not *medically necessary*.
- f. *Durable medical equipment* that we determine to be for your comfort, personal hygiene, or convenience including, but not limited to, physical fitness equipment, *health care practitioner's* equipment, and self-help devices not medical in nature.
- g. Routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of a one-month rental billed every six months.
- h. Replacement of equipment unless we determine that it is *medically necessary*.
- i. Replacement of over-the-counter batteries.
- j. Repairs or replacement due to abuse or misuse as determined by us.

- k. Devices and computers to assist in communication and speech including speech aid devices and tracheo-esophageal voice devices.
- l. Blood pressure cuffs and monitors.
- m. Enuresis alarms.
- n. Trusses.
- o. Ultrasonic nebulizers.
- p. Oral appliances for snoring.
- q. Breastfeeding equipment.

O. Emergency Medical Care

1. Covered Emergency Medical Care:

- a. *Emergency medical care* in an emergency room, as described below:
 - 1) *Benefits* are payable for *health care services* provided in an emergency room as shown in the Schedule of Benefits. If a *copayment* is shown, this *copayment* applies to the *emergency room visit*.
 - 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*.
 - 3) If you receive *health care services* in a country other than the United States, please see Section XI. B.1. (Claim Filing and Processing Procedures / Filing Clams / How to File a Claim) for additional information
- 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 your Schedule of Benefits.

2. Emergency Medical Care Limitations:

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

- a. If follow-up care is needed after the *medical emergency* has passed coverage will be subject to all policy terms, conditions, and provisions. This includes but is not limited to *prior authorization* for additional *health care services*. Such services from a *non-preferred provider* will be paid at the *non-preferred provider* level of benefits.
- b. Covered health care services received from a non-preferred provider will be limited to the amounts that we determine to be the maximum out-of-network allowable fee. You will be responsible for the difference between the amount charged and the maximum out-of-network allowable fee.
- c. If an ambulance service is called and you are transported to an emergency room, coverage for any emergency medical care directly provided to you during your ambulance transport is payable under Section V.C. (Covered Expenses / Ambulance Services). If an *ambulance service* is called, but you are not transported, *emergency medical care* provided to you will be payable under this Section V.O., as shown in the Schedule of Benefits.

P. Hearing Aids, Cochlear Implants, and Related Treatment

This Section V. P. only applies to *covered dependent children* who are under age 18.

A. Definitions:

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

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

2. Covered Hearing Services:

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



- a. One *hearing aid* (including fitting and testing), per ear, per *covered person*;
- b. *Cochlear implants* including batteries and cords for such devices;
- c. *Treatment* related to *hearing aids* and *cochlear implants* covered under this Paragraph 2., including procedures for the implantation of *cochlear implants*.
- d. Post-*cochlear implant* aural therapy.

3. Hearing Services Exclusions:

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

- a. Hearing protection equipment.
- b. *Hearing aid* batteries and cords.
- c. *Hearing aids*, *cochlear implants* and related treatment provided to a *covered person* age 18 or over.
- d. Any other implantable hearing devices except as specifically stated in Paragraph 2. above.

Q. Home Care Services

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

1. Definitions:

- a. **Home Care:** *health care services* provided directly to you in your home under a written plan that meets the following criteria: (1) the plan is developed by your attending *health care practitioner*; (2) the plan is approved by your attending *health care practitioner* in writing; (3) the plan is reviewed by your attending *health care practitioner* every two months (or less frequently if your *health care practitioner* believes and we agree that less frequent reviews are enough); and (4) *home care* is provided or coordinated by a home health agency or certified rehabilitation agency that is licensed by the Wisconsin Department of Health Services or certified by Medicare.
- b. **Home health aide services:** nonmedical services performed by a home health aide which: (1) are not required to be performed by a registered nurse or licensed practical nurse; and (2) primarily aid the patient in performing normal *activities of daily living*, which may include *custodial care*.

2. Covered Home Care Services:

- a. Home safety evaluations, evaluations for a home *treatment* program, and/or initial visit(s) to evaluate you for an independent treatment plan;
- b. Part-time or intermittent home nursing care by or under supervision of a registered nurse;

- c. Part-time or intermittent *home health aide services* that consist solely of care for the patient as long as they are: (1) *medically necessary*; (2) appropriately included in the home care plan; (3) necessary to prevent or postpone *confinement* in a *hospital* or *skilled nursing facility*; and (4) supervised by a registered nurse or medical social worker;
- d. Physical or occupational therapy or speech-language pathology or respiratory care;
- e. *Medical supplies*, drugs and medications prescribed by a *health care practitioner*; and laboratory services by or on behalf of a *hospital* if needed under the home care plan. These items are covered to the extent they would be if you had been hospitalized;
- f. Nutrition counseling provided or supervised by a registered or certified dietician; and
- g. Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. Your attending *health care practitioner* must request or approve this evaluation.

3. Home Care Limitations:

- a. *Benefits* are limited to 40 *home care* visits per *covered person* per *coverage period*. Each visit by a person to provide services under a *home care* plan, to evaluate your need for *home care*, or to develop a *home care* plan counts as one *home care* visit. Each period of up to four straight hours of *home health aide services* in a 24-hour period counts as one *home care* visit.
- b. The maximum weekly *benefit* payable for *home care* won't be more than the *benefits* payable for the total weekly *charges* for *skilled nursing care* available in a licensed *skilled nursing facility*, as determined by us.

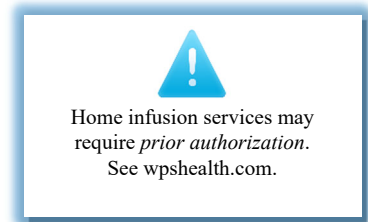
4. Home Care Exclusions:

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

- a. Home care that is not ordered by a health care practitioner; or
- 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.

R. 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.



S. Hospital Services

Transplant services are not covered under this Section V. S., please see Section V. JJ. (Covered Expenses / Transplants) for this coverage information. This Section V. S. does not include *charges* for outpatient physical, speech, or occupational therapy; please see Section V. II. (Covered Expenses / Therapy Services). Additionally, inpatient *hospital services* for detoxification are covered under this Section V. S.

1. Covered Hospital Services:

- a. **Inpatient Hospital Services.** *Benefits* are payable for the following inpatient *hospital services* for an *illness* or *injury*:
 - 1) *Charges* for room and board;
 - 2) *Charges* for nursing services;
 - 3) *Charges* for miscellaneous *hospital expenses*; and
 - 4) *Charges* for intensive care unit room and board.



- b. **Outpatient Hospital Services.** *Benefits* are payable for *miscellaneous hospital expenses*, including services in *observation care*, for an *illness* or *injury* received by you while you are not *confined* in a *hospital*.
- c. **Facility Fees.** *Benefits* are payable for facility fees *charged* by the *hospital* for *office visits* and for *urgent care* visits.

2. Hospital Services Limitations:

- a. If you are *confined* in a *hospital* other than a preferred *hospital* as an inpatient due to a *medical emergency*, we reserve the right to coordinate your transfer to a preferred *hospital* once you are stable and can be safely moved to that preferred *hospital*.
- b. If you are stable and refuse such transfer, further services in the non-preferred *hospital* will not be covered at the *preferred provider* benefit level.
- c. We will not cover inpatient stays at a *hospital* if care could safely and effectively be provided to you in a less acute setting.

T. Kidney Disease Treatment

- 1. **Covered 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 V. JJ. (Covered Expenses / Transplants).

- 2. **Kidney Disease Treatment Limitations** Such services are limited to amount stated in the Schedule of Benefits.

U. Mastectomy Treatment

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

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

V. 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*, or your home. *Medical services* covered under this Section V. V. do not include *health care services* covered elsewhere in the Policy, including *home care* services covered under Section V. Q. (Covered Expenses / Home Care Services).

W. Medical Supplies

- 1. **Covered Medical Supplies:** *Medical supplies* prescribed by a *health care practitioner*, including but not limited to:
 - a. Strapping and crutches; and
 - b. Disposable *supplies*, tubing, and masks for the effective use of covered *durable medical equipment*.

2. Medical Supplies Exclusions:

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

- a. *Medical supplies* that we determine to be for your comfort, personal hygiene, or convenience including, but not limited to disposable *supplies*.
- b. *Ostomy supplies*.
- c. Over-the-counter ace bandages, gauze and dressings.
- d. Compression stockings that you purchase from a *durable medical equipment* provider or *pharmacy*.

X. Orthotics

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

- a. Casts and splints;
- b. Orthopedic braces, including necessary adjustments to shoes to accommodate braces;
- c. Cervical collars;
- d. Corsets (back and special surgical); and
- e. *Orthotics* to support the foot which are part of an orthopedic leg brace;

2. Orthotics Limitations:

- a. *Benefits* will be limited to standard devices as determined by us.
- b. *Orthotics* may be replaced once per *calendar year* per *covered person* if *medically necessary*. Additional replacements will be allowed:
 - 1) if you are under age 19 and due to rapid growth; or
 - 2) when the *orthotic* is damaged and cannot be repaired.

3. Orthotics Exclusions:

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

- a. Routine periodic maintenance such as testing, cleaning and checking of the device or appliance.
- b. *Orthotics* to support the foot which are not a permanent part of an orthopedic leg brace.
- c. Diabetic shoes and orthopedic shoes.
- d. Repairs due to abuse or misuse as determined by us.

Y. Pain Management Treatment

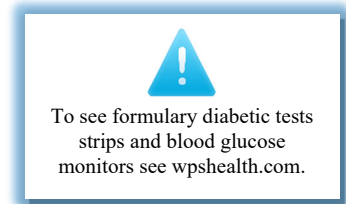
Pain management *treatment* including injections and other procedures to manage your pain related to an *illness* or *injury*.



Z. Prescription Legend Drugs and Supplies

1. Definitions. The following definitions apply to this Subsection V. Z. only:

- a. **Biosimilar(s):** a *prescription legend drug* of biological origin developed such that there are no clinically meaningful differences between the biological product and its FDA-approved reference product in terms of safety, purity, and potency, and demonstrates similarity to the reference product in terms of quality characteristics, biological activity, safety and efficacy. A *biosimilar* may be classified as a *brand-name drug*, *generic drug*, and /or *specialty drug*.
- b. **Brand-Name Drug(s):** a *prescription legend drug* sold by the pharmaceutical company or other legal entity holding the original United States patent for that *prescription legend drug*. For purposes of the Policy, we may classify a *brand-name drug* as a *generic drug* if we determine that its price is comparable to the price of the equivalent *generic drug*. The term *brand-name drug* may also include over-the-counter drugs that we determine to be covered drugs.
- c. **Drug Deductible:** the specified amount you are required to pay for covered drugs and covered supplies per *coverage period*.
- d. **Generic Drug(s):** a *prescription legend drug*, whether identified by its chemical, proprietary, or non-proprietary name, that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA. For purposes of the Policy, we may classify a *generic drug* as a *brand-name drug* if we determine that the *generic drug's* price is comparable to the price of its *brand-name* equivalent. The term *generic drug* may also include over-the-counter drugs that we determine to be covered drugs.
- e. **Preferred Pharmacy:** a pharmacy that we have contracted with and that bills us directly for the *charges* you incur for covered drugs.
- f. **Preferred Drug(s):** any *generic drug* or *brand-name drug* named on our list of *preferred drugs*, which is available at <https://wpshealth.com/resources/customer-resources/pharmacy-info.shtml>. The list of *preferred drugs* may change from time to time.
- g. **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.
- h. **Specialty Drugs:** *prescription legend drugs* that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost. To determine if a drug is a specialty drug and if that specialty drug requires our *prior authorization*, visit our website at wpshealth.com or call the telephone number shown on your identification card.
- i. **Specialty Pharmacy:** a *preferred pharmacy* designated by us to dispense *specialty drugs*. To locate a *specialty pharmacy*, contact us by calling the telephone number shown on your identification card or visit the website of the pharmacy benefit manager listed on your identification card.



2. Covered Drugs.

- a. Any *prescription legend drug* not otherwise excluded or otherwise limited under the Policy;
- b. Any medicine a *preferred pharmacy* compounds as long as it contains at least one *prescription legend drug* that is not excluded under the Policy, provided it is not considered *experimental/investigational/unproven* or not *medically necessary*; if a compound drug contains non-covered ingredients, reimbursement will be limited to the covered *prescription legend drug(s)*;
- c. Injectable insulin;
- d. *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;

- e. Oral chemotherapy drugs; and
 - f. *Experimental/investigational/unproven* drugs that are FDA-approved, administered according to protocol, and required by law to be covered.
- 3. Covered Supplies.**
- a. Insulin syringes and needles;
 - b. Lancets and lancet devices;
 - c. Formulary diabetic test strips;
 - d. Alcohol pads;
 - e. Formulary blood glucose monitors;
 - f. Auto injector; and
 - g. Glucose control solution.
- 4. Our Discretion.** We have full discretionary authority to cover drugs or supplies that vary from the *benefits* described in the Policy if there is an advantage to both you and us.
- 5. Cost Sharing.** See your Schedule of Benefits for information about *cost sharing* and maximum benefit amount that applies to drugs and supplies. All covered drugs and supplies are subject to the *drug deductible* and maximum benefit amount per *coverage period* listed in your Schedule of Benefits.
- 6. Prescription Legend Drugs and Supplies Limitations.**
- a. **If You Do Not Utilize a Preferred Pharmacy.** If drugs and *supplies* are dispensed to you by a pharmacy other than a *preferred pharmacy* or *specialty pharmacy* are payable as follows. If you utilize a non-preferred pharmacy, you must pay for the covered 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 *drug deductible* and any difference between our *benefit* payment and the price you paid for the covered drug or supply.
 - b. **Step Therapy.** If there is more than one *prescription legend drug* that has been determined to be safe and effective for the *treatment* of your *illness* or *injury*, we may only provide *benefits* for the less expensive *prescription legend drug*. Alternatively, we may require you to try the less expensive *prescription legend drug(s)* before *benefits* are payable for any other alternative *prescription legend drug(s)*.
 - c. **Prior Authorization.** We have full discretionary authority to require *prior authorization* for certain drugs before they are eligible for coverage under the Policy. This applies to all *prescription legend drugs*, including *specialty drugs* and drugs administered by a *health care provider*. To determine whether a drug requires *prior authorization*, visit wpshealth.com or call the telephone number shown on your identification card. If you do not receive *prior authorization* before receiving such drugs, *benefits* may not be payable under the Policy.
 - 1) 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*.
 - 2) After receiving the required information, we (or our *delegate*) will determine if the drug is covered under the Policy and notify you of our coverage determination. If we determine that the *treatment* is not a covered drug or is otherwise excluded under the Policy, no *benefits* will be payable for that drug.

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

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

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

Item	Quantity Limit
<i>Prescription legend drugs or supplies</i> dispensed by a retail pharmacy	30-day supply per fill or refill
<i>Specialty drugs</i>	30-day supply per fill or refill
Blood glucose monitor dispensed by a <i>preferred pharmacy</i>	One per <i>covered person</i> per <i>coverage period</i> .

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

7. 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 VI. (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;
- c. Refills of otherwise covered drugs that exceed the number your prescription order calls for;
- d. Refills of otherwise covered drugs after one year from the date of the prescription order;
- e. Drugs usually not charged for by the health care provider;
- f. A drug that is completely administered at the time and place of the *health care provider* who dispenses it under the *prescription order*, except for immunizations and drugs for which you receive our *prior authorization*;
- g. Anabolic drugs, unless we determine that they are being used for accepted medical purposes and eligible for coverage under the Policy;
- h. Progesterone or similar drugs in any compounded dosage form;
- i. Costs related to the mailing, sending or delivery of prescription legend drugs;

- j. Refill of drugs, medicines, medications or supplies that are lost, stolen, spilled, spoiled, damaged, or otherwise rendered unusable;
- k. Any drug or medicine that is available in prescription strength without a prescription order, except as determined by us;
- l. More than one fill or refill for the same covered supply, covered drug or therapeutic equivalent medication prescribed by one or more *health care practitioner* until you have used at least 75% of the previous retail prescription.
- m. Charges that are reduced by a manufacturer promotion (e.g., coupon or rebate);
- n. Any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you;
- o. Any compounded drug that is substantially like a commercially available product;
- p. Any drug delivered to or received from a destination outside of the United States;
- q. Any drug for which prior authorization is required but not obtained;
- r. Any drug for which step therapy is required but not followed;
- s. Non-legend vitamins, minerals, and supplements even if prescribed by a health care practitioner;
- t. All medicinal foods, enteral feedings, supplemental feedings, nutritional and electrolyte supplements, and infant formula;
- u. Any drug or agent used for cosmetic treatment; for example, wrinkles or hair growth;
- v. Any drug in unit-dose packaging except as required by law; and
- w. Immunizations.

AA. Preventive Care Services

1. Covered Preventive Care Services:

The following *preventive care services* are covered to the extent required by law.:

- a. One routine mammogram of a *covered person per coverage period*;
- b. Blood lead tests for children under age six;
- c. Immunizations for children under age six, including, but not limited to diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; haemophilus influenza B; hepatitis B; and varicella.
- d. Colorectal cancer screening, including fecal occult blood testing and colonoscopy in accordance with the most current guidelines of the United States Preventive Services Task Force.

2. Preventive Care Services Exclusions:

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

- a. Immunizations for travel purposes.
- b. *Preventive care services* other than those listed in Paragraph 1. above.

BB. Prosthetics

1. Covered Prosthetics:

- a. Prosthetic devices and related *supplies*, including the fitting of such devices, that replace all or part of:
 - 1) An absent body part (including contiguous tissue); or
 - 2) The function of a permanently inoperative or malfunctioning body part.
- b. Covered prosthetic devices include, but are not limited to, artificial limbs, eyes, and larynx. *Benefits* are limited to one purchase of each type of the standard model in a *coverage period*, as determined by us.
- c. Replacement or repairs of prosthetics if we determine that they are *medically necessary*.

2. Prosthetics Exclusions:

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

- a. Prosthetics that we determine to have special features that are not medically necessary.
- b. Dental prosthetics.
- c. Repairs due to abuse or misuse.

CC. Pulmonary Rehabilitation

Outpatient pulmonary rehabilitation therapy limited to 24 visits per covered *illness* per *coverage period*. No other *benefits* for outpatient pulmonary rehabilitation therapy are available under the Policy.

DD. 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.

EE. Skilled Nursing Care in a Skilled Nursing Facility

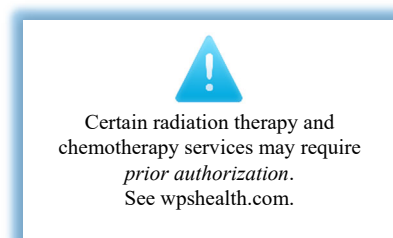
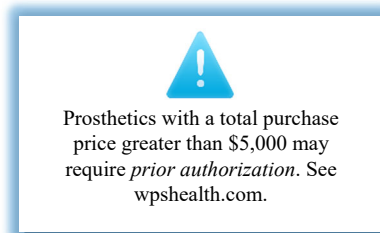
1. Covered Skilled Nursing Care:

Skilled nursing care provided to you during your *confinement* in a *skilled nursing facility* if: (1) you are admitted to a *skilled nursing facility* within 24 hours after discharge from a *hospital* or surgical center or directly from emergency room care, urgent care, or a *health care practitioner's* office; and (2) you are admitted for continued *treatment* of the same *illness* or *injury*.

2. Skilled Nursing Care Limitations:

- a. *Skilled nursing care* is limited to 30 days per *confinement* per covered person.
- b. Each day of your *confinement* will count towards this 30-day limit, regardless of whether the *charges* are applied to your *deductible* or paid by us under the Policy.
- c. *Skilled nursing care* must be certified as *medically necessary* by your attending *health care practitioner* every seven days.

3. Skilled Nursing Care Exclusions:



This Policy provides no *benefits* for any items listed below. These exclusions apply in addition to the exclusions outlined in Section VI. (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 V. Q. (Covered Expenses / Home Care Services), or care in an outpatient setting).
- b. Domiciliary care, such as meals-on-wheels, health visiting, and home help, provided by a welfare agency for people in their own homes.
- c. *Maintenance care, supportive care, or custodial care.*
- d. Care that is available at no cost to you or care provided under a governmental health care program (other than a program provided under Wis. Stat. Chapter 49).

FF. Surgical Services

This Section V. FF. does not include *surgical services* for: (1) covered transplants; or (2) pain management procedures. Please see Section V. Y. (Covered Expenses / Pain Management Treatment), and Section V. JJ. (Covered Expenses / Transplants) for this coverage information.

1. Definitions:

- a. **Incidental/Inclusive:** a procedure or service is *incidental/inclusive* if it is integral to the performance of another *health care service* or if it can be performed at the same time as another *health care service* without adding significant time or effort to the other *health care service*.
- b. **Oral Surgery:** *surgical services* performed within the oral cavity.

2. Covered Surgical Services:

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

- a. Surgical services, other than reconstructive surgery and oral surgery.
Covered surgical services include but are not limited to:
 - 1) Operative and cutting procedures;
 - 2) Endoscopic examinations, such as: (a) arthroscopy; (b) bronchoscopy; or (c) laparoscopy; and
 - 3) Other invasive procedures such as: (a) angiogram; and (b) arteriogram.
- b. *Reconstructive surgery* when the primary purpose of the surgery is to correct *functional impairment* caused by an *illness, injury, congenital abnormality, acute traumatic injury, dislocation, tumors, cancer, obstructive sleep apnea, or temporomandibular joint disorder*. Please note that breast reconstruction following a mastectomy, reconstruction of the non-affected breast to achieve symmetry, and other services required by the Women's Health and Cancer Rights Act of 1998 are covered under Section V. U. (Covered Expenses / Mastectomy Treatment).
- c. *Oral surgery*, including related consultation, x-rays and anesthesia, limited to:
 - 1) The excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - 2) Oral reconstructive maxillofacial surgery.
- d. 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*.
- e. Congenital heart disease surgeries.



Spinal surgery and certain other surgeries may require *prior authorization*.
See wpshealth.com.

3. Surgical Services Exclusions:

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

- a. Incidental/inclusive surgical procedures that are performed in the same operative session as a major covered surgical procedure, which is the primary procedure. Benefits for incidental/inclusive surgical procedures are limited to the charge for the primary surgical procedure with the highest charge, as determined by us. No additional benefits are payable for incidental/inclusive surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an incidental/inclusive surgical procedure; therefore, benefits are payable for the hysterectomy, but not for the removal of the appendix.
- b. Oral surgery, except as specifically stated in Paragraph 2. c. above.
- c. Reconstructive surgery for purposes other than to correct functional impairment.
- d. Any surgical service that we determine to be cosmetic treatment, except as otherwise indicated in the Policy.
- e. Magnetic sphincter augmentation (Linx® System); transoral incisionless fundoplication procedures.

GG. Telemedicine

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

2. **Covered Telemedicine Services:**

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

NOTE: *Telemedicine* services provided by our designated telehealth service provider are covered as stated in your Schedule of Benefits. Visit <https://wpshealth.com/resources/customer-resources/telehealth.shtml> or call the Customer Service telephone number shown on your identification card for additional information about this *benefit*.

3. **Telemedicine Exclusions:**

This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section VI. (General Exclusions). Telemedicine services that do not include direct contact between the health care practitioner and the covered person.

- a. Transmission fees.
- b. Website charges for online patient education material.
- c. Telecommunications including but not limited to instant messaging, text messaging, email communication, or facsimile communication.

HH. Temporomandibular Joint (TMJ) Disorder Services

1. **Covered TMJ Disorder Services:**

- a. Diagnostic procedures and surgical and non-surgical *treatment* for the correction of TMJ disorders if all of the following apply:
 - 1) The disorder is caused by congenital, developmental or acquired deformity, *illness* or *injury*;
 - 2) Under the accepted standards of the profession of the *health care practitioner* providing the service, the procedure is reasonable and appropriate for the diagnosis or *treatment* of the condition; and
 - 3) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

- b. Non-surgical *treatment* includes coverage for prescribed intraoral splint therapy devices.
2. **TMJ Disorder Services Limitation:** TMJ disorder services are subject to the *coverage period* limit stated in the Schedule of Benefits for each *covered person*.
 3. **TMJ Disorder Services Exclusions:**

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

- a. Elective orthodontic care, periodontic care or general dental care.
- b. *Health care services* provided in connection with the temporomandibular joint or TMJ disorder, except as specifically stated in Paragraph 1. above.

II. Therapy Services

1. Definitions:

- a. **Habilitative Services:** *health care services* that help a person keep, learn, or improve skills and functioning for *activities of daily living*. Examples include, but are not limited to, therapy for a *child* who isn't walking or talking at the expected age. These *health care services* may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- b. **Rehabilitative Services:** *health care services* that help a person keep, get back or improve skills and functioning for *activities of daily living* that have been lost or impaired because a person had an *illness, injury* or was disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
- c. **Therapy Visit:** a meeting between you and a *health care practitioner*, excluding a massage therapist that: (1) occurs in the *health care practitioner's* office, a medical clinic, *convenient care clinic*, a free-standing *urgent care* center, *skilled nursing facility*, or the outpatient department of a *hospital*, other than a *hospital's* emergency room; and (2) involves you receiving physical, speech, or occupational therapy.

2. Therapy Limitations:

- a. Outpatient *therapy visits* are limited as follows:
 - 1) *Rehabilitative services* are subject to the *coverage period* limit stated in your Schedule of Benefits for each *covered person*.
 - 2) Massage therapy is covered only when the therapy is billed by a chiropractor, physical therapist or occupational therapist;
- b. All therapy must be expected to provide significant measurable gains that will improve your physical health.
- c. All therapy must be performed by a *health care practitioner*. If a license to perform such therapy is required by law, that therapist must be licensed by the state in which he/she is located and must provide such therapy while he/she is acting within the lawful scope of his/her license.

3. Therapy Exclusions:

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

- a. Physical therapy for TMJ disorders, except as specifically stated in Section V. HH. (Covered Expenses / Temporomandibular Joint (TMJ) Disorder Services).
- b. *Habilitative services*.



- c. Massage therapy or aquatic therapy, except as specifically stated in Paragraph 2. above.
- d. Long-term therapy and maintenance therapy, except as specifically stated in Paragraph 2. above.
- e. Therapy services provided by a massage therapist

JJ. Transplant Services

1. Definitions. The following definitions apply to this Section V. JJ. only:

- a. **Covered Transplant Drugs:** immunosuppressant drugs prescribed by a physician when dispensed by a health care provider while you are not confined in a hospital. These drugs do not include high dose chemotherapy, except for high dose chemotherapy provided for a covered bone marrow transplant. This includes refills of immunosuppressant drugs.
- b. **Designated Transplant Facility:** a facility that is (1) approved by us to be the most appropriate facility for your approved transplant services; (2) contracted to provide approved transplant services to covered persons pursuant to an agreement with one of our transplant provider networks, (3) a preferred provider when transplant services are provided while you are not confined in a hospital; or (4) any other health care provider approved by us. Designated transplant facilities are shown in the Schedule of Benefits as preferred providers.
- c. **Non-Designated Transplant Facility:** a facility that does not have an agreement with the transplant provider network with which we have a contract. This may include facilities that are listed as preferred providers. Non-designated transplant facilities are shown in the Schedule of Benefits as non-preferred providers.
- d. **Organ and Tissue Acquisition:** the harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to you. This includes related medical expenses of a living donor.
- e. **Transplant Services:** approved health care services for which a prior authorization has been received and approved for transplants when ordered by a physician. Such services include, but are not limited to, hospital charges, health care *practitioner's charges*, *organ and tissue acquisition*, tissue typing, and ancillary services.

2. Prior Authorization and Cost-Sharing Requirements:

- a. All *transplant services* require prior authorization. It is your responsibility to obtain a prior authorization for all transplant related services, including but not limited to the initial transplant evaluation. The transplant must meet our medical necessity criteria for such transplant and may not be experimental/investigational/unproven.
- b. If prior authorization is obtained, we will pay benefits for charges for covered expenses you incur at a designated transplant facility or non-designated transplant facility as determined by us during the prior authorization process for an illness or injury.
- c. Transplant benefits are subject to any *deductibles* and *coinsurance* amounts shown in the Schedule of Benefits.

3. Covered Transplant Services:

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

- a. *Hospital charges.*
- b. *Health care practitioner charges.*
- c. *Organ and tissue acquisition.*
- d. Tissue typing.
- e. Ancillary services.
- f. Post-transplant complications, if you are the recipient.



- g. Post-harvesting complication, if you are a donor.
- h. *Covered transplant drugs* as described in Section V. Z. (Prescription Legend Drugs and Supplies)

4. Transplant Services Exclusions:

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

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

KK. 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 keratoconus.

2. Vision Services Exclusions:

This Policy provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section VI. (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 in the Policy;
- e. Correction of visual acuity or refractive errors by any means, except as specifically stated in the Policy;
- f. Implantable specialty lenses, including, but not limited to, toric astigmatism-correcting lenses and multifocal presbyopia-correcting intraocular lenses to improve vision following cataract surgery;
- g. Replacement lenses, frames, or contact lenses due to loss, theft, or damage; and
- h. Routine eye exams.



VI. GENERAL EXCLUSIONS

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

- A. Health care services that we determine are not medically necessary.
- B. Health care services that we determine are *experimental/investigational/unproven*, except for the following, which are covered under the Policy as described in Section V. Z. (Covered Expenses / Prescription Legend Drugs and Supplies):

1. Investigational drugs for the *treatment* of HIV infection as described in Wis. Stat. § 632.895(9); and
 2. Drugs that by law require a written prescription used in the *treatment* of cancer that may not currently have the FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate *treatment* for that diagnosis.
- C. *Health care services* for which expenses are incurred as a result of a *pre-existing injury* or *illness*, including any complications of such *pre-existing illness* or *injury*.
 - D. *Health care services* provided for the *treatment* of an *illness* prior to the seventh day following your effective date
 - E. *Health care services* that we determine to be *cosmetic treatment*, except as otherwise provided in the Policy.
 - F. *Maintenance care* or *supportive care*.
 - G. *Health care services* provided in connection with any *injury* or *illness* arising out, or sustained in the course, of any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance. This exclusion applies regardless of whether benefits under workers' compensation laws or any similar laws have been claimed, paid, waived, or compromised.
 - H. *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.
 - I. *Health care services* furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless such coverage under the Policy is required by law.
 - J. The amount of *benefits* that are covered by, or would be covered by, Medicare as the primary payer if you are eligible for Medicare. This applies regardless of whether you are actually enrolled in Medicare See Section VII. H. (Coordination of Benefits / Coverage with Medicare) for additional information.
 - K. *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.
 - L. *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.
 - M. *Custodial care* except *home health aide services* as covered in Section V. Q. (Covered Expenses / Home Care Services).
 - N. *Charges* in excess of the *maximum allowable fee* or *maximum out-of-network allowable fee*.
 - O. Chelation therapy, except in the *treatment* of heavy metal poisoning.
 - P. *Health care services* provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in custody of law enforcement officials, except as required under Wis. Stat. § 609.65. This exclusion does not apply to *covered persons* on work-release.
 - Q. Completion of forms, including but not limited to claim forms or forms necessary for the return to work or school.
 - R. An appointment you did not attend.
 - S. *Health care services* for which you have no obligation to pay or which are provided to you at no cost.
 - T. *Health care services* related to a non-covered *health care service*. When a service is not a covered *health care service*, all services related to that non-covered *health care service* are also excluded, except for *complication of pregnancy*.
 - U. *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.
 - V. Private duty nursing.

- W.** Transportation or other travel costs associated with a *health care service*, except as specifically provided in Section V. C. (Covered Expenses / Ambulance Services).
- X.** *Health care services* that are excluded elsewhere in the Policy.
- Y.** *Health care services* not specifically identified as being covered under the Policy, except for those *health care services* approved by us subject to Section V. B. (Covered Expenses / Alternative Care).
- Z.** *Health care services* provided when your coverage was not effective under the Policy. Please see Section II. (Special Enrollment Options) and Section VIII. (When Coverage Ends).
- AA.** *Health care services* not provided by a *health care practitioner* or any of the *health care providers* listed in Section V. (Covered Expenses).
- BB.** The following procedures and any related *health care services*:
 1. Injection of filling material (collagen) other than for incontinence;
 2. Salabrasion;
 3. Rhytidectomy (face lift);
 4. Dermabrasion;
 5. Chemical peel;
 6. Suction-assisted lipectomy (liposuction);
 7. Hair removal;
 8. Mastopexy;
 9. Mammoplasty, including augmentation or reduction mammoplasty (except for reconstruction associated with a covered mastectomy);
 10. Correction of inverted nipples;
 11. Sclerotherapy or other *treatment* for varicose veins less than 3.5 millimeters in size (*e.g.* telangiectasias, spider veins, reticular veins);
 12. Excision or elimination of hanging skin on any part of the body, such as panniculectomy; abdominoplasty and brachioplasty;
 13. Mastectomy for gynecomastia;
 14. Botulinum toxin or similar products, unless you receive our *prior authorization*;
 15. Any modification to the anatomic structure of a body part that does not affect its function;
 16. Labiaplasty;
 17. *Treatment* of sialorrhea (drooling or excessive salivation); and
 18. Medical and surgical *treatment* of excessive sweating (hyperhidrosis).
- CC.** *Health care services* provided at any nursing facility or convalescent home or *charges* billed by any place that is primarily for rest, the aged, or the *treatment of substance use disorders*.
- DD.** *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.

- EE.** Housekeeping, shopping, or meal preparation services.
- FF.** *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.
- GG.** *Health care services* for treatment of an *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; or rodeo sports;
- HH.** *Health care services* for treatment of an *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following if the *covered person* is paid to participate or instruct: operating or riding on a motorcycle; racing or speed testing any non-motorized vehicle or conveyance; horseback riding; rock or mountain climbing; or skiing;
- II.** *Health care services* for *treatment* of an *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
- JJ.** *Health care services* for *treatment* of an *injury* sustained while engaged in farming if the covered person works with any of the following: animal raising, cattle or livestock raising, goat or sheep raising, dairy industry, egg or poultry industry, field crops, vegetables and orchards.
- KK.** *Health care services* for which proof of claim isn't provided to us as required by the Policy.
- LL.** *Health care services* not for or related to an *illness* or *injury*, other than as specifically stated in the Policy.
- MM.** Sales tax or any other tax, levy, or assessment by any federal or state agency or local political subdivision.
- NN.** Costs associated with indirect services provided by *health care providers* such as: creating standards, procedures, and protocols; calibrating equipment; supervising testing; setting up parameters for test results; reviewing quality assurance data; transporting lab specimens; concierge payments; translating claim forms or other records; and after-hours *charges*.
- OO.** *Health care services* for the *treatment* of weak, strained, flat, unstable or unbalanced feet.
- PP.** *Health care services* for *treatment* of sexual dysfunction, including impotence, regardless of the cause of the dysfunction. This includes: (a) *surgical services*; (b) devices; (c) penile implants; and (d) sex therapy.
- QQ.** Storage of blood tissue, cells, or any other body fluids.
- RR.** Salivary hormone testing.
- SS.** *Health care services* performed while outside of the United States, except in the case of a *medical emergency*.
- TT.** Prolotherapy.
- UU.** Platelet-rich plasma.
- VV.** Coma stimulation/recovery programs.
- WW.** Environmental items including, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.
- XX.** Wigs, toupees, hairpieces, cranial prosthesis, hair implants, or transplants or hair weaving, or hair loss prevention treatments.
- YY.** Car seats.
- ZZ.** Modifications to your vehicle, home or property including, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, chair lifts, grab bars, raised toilet seats, commodes, and ramps.

- AAA.** *Health care services* used in educational or vocational training or testing.
- BBB.** *Health care services* associated with expenses for infertility, including assisted reproductive technology, except for those services related to a covered medical condition.
- CCC.** *Health care services* associated with pregnancy (except for any *complication of pregnancy*);
- DDD.** Direct attempts to achieve pregnancy or increase chances of achieving pregnancy by any means.
- EEE.** Any laparoscopic procedure during which an ovum is manipulated for the purpose of fertility treatment even if the laparoscopic procedure includes other purposes.
- FFF.** Medications for which the primary purpose is to preserve fertility.
- GGG.** *Health care services* for holistic, complementary, alternative or homeopathic medicine or other programs that are not accepted medical practice, as determined by us, including, but not limited to, aromatherapy, herbal medicine, naturopathy, reflexology, and programs with an objective to provide personal fulfillment.
- HHH.** Hypnosis.
- III.** Acupuncture.
- JJJ.** Biofeedback.
- KKK.** Therapy services such as recreational therapy, educational therapy, physical fitness, or exercise programs, except as specifically stated in Sections V. H. (Covered Expenses / Cardiac Rehabilitation Services) and V. II. (Covered Expenses / Therapy Services).
- LLL.** Photodynamic therapy and laser therapy for the *treatment* of acne.
- MMM.** Vocational or industrial rehabilitation including work hardening programs.
- NNN.** Sports hardening and rehabilitation.
- OOO.** *Health care services* that are solely for educational, occupational or athletic purposes and not for *treatment* of an *illness* or *injury*.
- PPP.** 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.
- QQQ.** *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*. Services excluded under this provision include, but are not limited to:
 1. Gastric or intestinal bypasses;
 2. Gastric balloons or banding;
 3. Stomach stapling;
 4. Wiring of the jaw;
 5. Liposuction;
 6. Any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you;
 7. Weight loss programs and nutritional counseling, unless *benefits* are provided elsewhere in the Policy;
 8. Physical fitness or exercise programs or equipment, unless *benefits* are provided elsewhere in the Policy; and
 9. Bone densitometry (DEXA, DXA) scans.

- RRR.** *Health care services* performed by a *health care practitioner* who is a family member by birth, marriage or domestic partnership. Examples include a spouse, domestic partner, brother, sister, parent or *child*. This includes any *health care service* the provider may perform on himself or herself.
- SSS.** *Health care services* performed by a *health care practitioner* with your same legal residence.
- TTT.** Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
- UUU.** *Hospice care and respite care.*
- VVV.** Joint replacement, unless related to an *injury* that is covered under this Policy.
- WWW.** Non-emergency *treatment* of adenoids, hemorrhoids, hernia, or tonsils.
- XXX.** Any *illness* or *injury* incurred as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *health care practitioner*;
- YYY.** *Health care services* to treat *nervous or mental disorders* or *substance use disorders*.
- ZZZ.** *Health care services* provided by wilderness programs, boot camps, therapeutic boarding schools, and outward-bound programs.
- AAAA.** Bereavement counseling.
- BBBB.** Marriage counseling.
- CCCC.** Genetic testing.

VII. COORDINATION OF BENEFITS (COB)

A. Definitions

The following definitions apply to this Section VII. only:

1. **Allowable Expense:** a *health care service* or expense, including *deductibles* and *copayments*, that is covered at least in part by one or more *plans* covering the person for whom the claim is made. When a *plan* provides *benefits* in the form of services, the reasonable cash value of each service provided will be considered both an *allowable expense* and a *benefit* paid.
2. **Claim Determination Period:** a calendar year. However, it does not include any part of a year during which a person has no coverage under the Policy or any part of a year before the date this Section VII. or a similar provision takes effect.
3. **Plan:** any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
 - a. Individual or group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - b. Coverage under a governmental plan or coverage that is required or provided by law. It does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
 - c. Medical expense benefits coverage in group, group-type and individual automobile “no-fault” contracts but, as to the traditional automobile “fault” contracts, only the medical benefits written on a group or group-type basis are included.

Each contract or other arrangement for coverage under Paragraphs 3. a., b., or c. above is a separate *plan*. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate *plan*.

Primary Plan/Secondary Plan: Subsection C. (Order of Benefit Determination Rules) below states whether the Policy is a *primary plan* or *secondary plan* as to another *plan* covering the person. When the Policy is a *primary plan*, its *benefits* are determined before those of the other *plan* and without considering the other *plan's* benefits. When the Policy is a *secondary plan*, its *benefits* are determined after those of the other *plan* and may be reduced because of the other *plan's* benefits. When there are more than two *plans* covering the person, the Policy may be a *primary plan* as to one or more other *plans* and may be a *secondary plan* as to a different *plan* or *plans*.

B. Applicability

1. This Section VII. applies when you have health care coverage under the Policy and another *plan*.
2. If this Section VII. applies, the order of *benefit* determination rules will be looked at first. The rules determine whether the *benefits* of the Policy are determined before or after those of another *plan*. The *benefits* of the Policy:
 - a. Will not be reduced when, under the order of benefit determination rules, the Policy determines its benefits before another plan; but
 - b. May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. This reduction is described in Subsection D. (Effect on the Benefits of the Policy) below.

C. Order of Benefit Determination Rules

1. When there is a basis for a claim under the Policy and another *plan*, the Policy is a *secondary plan* unless:
 - a. The other plan is automobile medical expense benefit coverage or has rules coordinating its benefits with those of the Policy; and
 - b. Both those rules and the Policy's rules described in Paragraph 2. below require that the Policy's benefits be determined before those of the other *plan*.
2. The Policy determines its order of *benefits* using the first of the following rules which applies:
 - a. **Non-dependent/Dependent.** The benefits of the *plan* which covers the person as an employee, member or *subscriber* are determined before those of the *plan* which covers the person as a dependent of an employee, member or *subscriber*.
 - b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in Paragraph 2. c. below, when the Policy and another *plan* cover the same *child* as a dependent of different persons, called "parents", the benefits of the *plan* of the parent whose birthday falls earlier in the calendar year are determined before those of the *plan* of the parent whose birthday falls later in that calendar year; but if both parents have the same birthday, the benefits of the *plan* which covered the parent longer are determined before those of the *plan* which covered the other parent for a shorter period of time.

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

Also, if the specific terms of a court decree state that the parents have joint custody and do not specify that one parent has responsibility for the *child's* health care expenses or if the court decree states that both parents

will be responsible for the health care needs of the *child* but gives physical custody of the *child* to one parent, and the entities obligated to pay or provide the benefits of the respective parents' *plans* have actual knowledge of those terms, benefits for the dependent *child* will be determined according to Paragraph 2. b. above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the *child*, and the entity obligated to pay or provide the benefits of the *plan* of that parent has actual knowledge of those terms, the benefits of that *plan* are determined first. This Paragraph 2. c. does not apply with respect to any *claim determination period* or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. **Active/Inactive Employee.** The benefits of a *plan* which covers a person as an employee who is neither laid-off nor retired or as that employee's dependent are determined before those of a *plan* which covers that person as a laid-off or retired employee or as that employee's dependent. If the other *plan* does not have this rule and if, as a result, the *plans* do not agree on the order of benefits, this Paragraph 2. d. is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the *plan* covering the person as a dependent of an active employee, the federal Medicare regulations will supersede this Paragraph 2. d.
- e. **Continuation Coverage.** If a person has continuation coverage under federal or state law and is also covered under another *plan*, the following will determine the order of *benefits*:
 - 1) First, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber;
 - 2) Second, the benefits under the continuation coverage; and
 - 3) If the other *plan* does not have the rule described in Subparagraph 1) and 2), and if, as a result, the *plans* do not agree on the order of *benefits*, this Paragraph 2. e. is ignored.
- f. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of *benefits*, the benefits of the *plan* which covered an employee, member, *subscriber* or *dependent* longer are determined before those of the *plan* which covered that person for the shorter time.
- g. **None of the Above.** If the preceding rules do not determine the *primary plan*, the *allowable expenses* will be shared equally between the *plans* meeting the definition of *plan* under this provision. In addition, the Policy will not pay more than it would have paid had it been the *primary plan*.

D. Effect on the Benefits of the Policy

- 1. **When This Subsection Applies.** This Subsection D. applies when, in accordance with Subsection C. (Order of Benefit Determination Rules), the Policy is a *secondary plan* as to one or more other *plans*. In that event, the *benefits* of the Policy may be reduced under this Subsection D. Such other *plan* or *plans* are referred to as “the other *plans*” below.
- 2. **Reduction in the Policy's Benefits.** The *benefits* of the Policy will be reduced when the sum of the following exceeds the *allowable expenses* in a *claim determination period*:
 - a. The *benefits* that would be payable for the *allowable expenses* under the Policy in the absence of this section; and
 - b. The benefits that would be payable for the *allowable expenses* under the other *plans*, in the absence of provisions with a purpose like that of this section, whether or not claim is made. Under this provision, the *benefits* of the Policy will be reduced so that they and the benefits payable under the other *plans* do not total more than those *allowable expenses*.

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

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

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

G. Right of Recovery

1. If the amount of the payments we made is more than we should have paid, we may recover the excess from one or more of:
 - a. The persons we paid or for whom we paid;
 - b. Insurance companies; or
 - c. Other organizations.
2. The “amount of the payments made” includes the reasonable cash value of any *benefits* provided in the form of services.

H. Coverage with Medicare

This Policy will coordinate benefits with Medicare in accordance with federal law. A *covered person* who is eligible for Medicare is considered enrolled in and covered under Medicare Parts A and B, whether or not he/she is actually enrolled in one or both parts of Medicare except for kidney disease treatment, limited to dialysis, transplantation, and donor-related services.

This Policy will coordinate benefits as if you were covered by Medicare for all covered expenses, except for kidney disease treatment, limited to dialysis, transplantation, and donor-related services. For example, if you are eligible to enroll in Medicare Part B but fail to do so, we will still determine benefits that are payable under this Policy as if you had Medicare Part B coverage and Medicare paid Part B benefits, even if Medicare didn’t pay any Part B benefits. You will be responsible for all covered expenses that would have been covered by Medicare.

VIII. WHEN COVERAGE ENDS

A. General Rules

1. We may terminate your coverage under the Policy at 11:59 p.m. on the earliest of the following dates:
 - a. The termination date shown in your completed application for coverage.
 - b. The date we determine that you have performed an act or practice that constitutes fraud or made an intentional material misrepresentation of material fact under the terms of the coverage.
 - c. The last day of the applicable grace period if the premium required for your coverage has not been paid to us in accordance with this Policy.
 - d. The day in which you die. If there is a remaining covered spouse we will provide an amended application. The remaining covered spouse must review, sign, and submit the amended application to continue coverage as a *subscriber* for himself/herself and *covered dependents*.

- e. The date you enter into military service, other than for assignment of less than 30 days.
 - f. The last day of the calendar month in which we receive the *subscriber's* request to terminate this Policy, unless he/she specifies a later Policy termination date (such date must be the last day of a calendar month).
 - g. The last day of the calendar month in which we received the *subscriber's* request to terminate coverage for any of his/her *dependents*, unless he/she specifies a later Policy termination date (such date must be the last day of a calendar month).
 - h. For a *subscriber's covered dependent*, the last day the *subscriber* has coverage.
 - i. For a *subscriber's* spouse who is a *covered person*, the last day the *subscriber's* spouse is married to the *subscriber* when the marriage ends due to divorce or annulment.
 - j. For a *child* who is a *covered dependent*, the earliest of the following dates, as determined by us:
 - 1) the last day of the calendar month in which the *child* reaches age 26, unless he/she is a *full-time student returning from military duty* or he/she qualifies as an *eligible dependent* due to his/her disability (see the definition of *eligible dependent* in Section XIV. (Definitions)); or
 - 2) for *step-children*, the last day the *subscriber's* spouse is married to the *subscriber*.
 - k. For a child of a covered dependent child (i.e. the *subscriber's* grandchild), the day before the subscriber's child reaches age 18.
2. It is the *subscriber's* responsibility to notify us of his/her *dependent* losing status as an *eligible dependent*. If he/she does not so notify us, the *subscriber* will be responsible for any claim payments made during the period of time the *dependent* was not an *eligible dependent*. You will not be eligible for renewal of this Policy after one of the following events occurs:
- a. The *subscriber* moves outside, or no longer resides in, the *geographical service area*; or
 - b. We cease to offer this Policy.

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

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

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

1. The day before he/she advises us that he/she does not intend to return to school full-time;
2. The day before he/she becomes employed full time;
3. The day before he/she obtains other health care coverage;
4. The day before he/she marries and is eligible for coverage under his/her spouse's health coverage;
5. The date coverage of the *subscriber* through whom he/she has dependent coverage under the Policy is discontinued or not renewed; or
6. One year following the date on which he/she ceased to be a *full-time student* due to the *medically necessary* leave of absence if he/she has not returned to school on a full-time basis.

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

C. Special Rules for Disabled Children

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

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

It is the *subscriber's* responsibility to notify us if his/her *child* no longer qualifies as an *eligible dependent*. If he/she does not so notify us, the *subscriber* will be responsible for any claim payments made on behalf of the *child* during the period of time he/she was not eligible for coverage under the Policy.

D. Disenrollment from the Plan

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

1. You allow an individual other than a *covered person* to use the identity of a *covered person* to obtain *health care services*; or
2. You have performed an act or practice that constitutes fraud or made an intentional material misrepresentation of material fact under the terms of the coverage.

IX. PREMIUM RATES, GRACE PERIOD AND COVERAGE PERIOD

A. Premium Rates

We determine the premium rates for this Policy and all subsequent premiums due for all *covered persons* under this Policy. Each premium for each payment period after the initial period of coverage must be paid directly to WPS at our Madison Office by the premium due date.

For subsequent payment periods, the *subscriber's* payment of the required premium by the premium due date shall keep this Policy in force for the payment period beginning on the first day of the calendar month following the premium due date for which such premium was paid through the last day of the calendar month, subject to Section VIII. (When Coverage Ends) and the payment period's grace period. The *subscriber's* failure to pay premium due for a payment period shall terminate this Policy in accordance with Section VIII. (When Coverage Ends).

B. Premium Due Date

The due date of your premium is indicated on your billing statement which you may receive on paper in the mail or will access through your customer account on our online portal. In order to keep your coverage in effect, you must pay your premium by the end of the applicable grace period after your premium due date. If we do not receive your premium payment, this Policy will terminate on the last day of the applicable grace period at 11:59 p.m.

The *subscriber* can terminate this Policy by notifying us prior to his/her next premium due date. After we receive such notice, your Policy will terminate in accordance with Section VIII. (When Coverage Ends). You must still pay us the premium for coverage provided during that period. If this Policy ends for any other reason before any paid-up payment period ends, any refunds will be prorated to the termination date from the date of last premium payment.

We're not responsible for notifying you when premiums are due for coverage provided during payment periods under this Policy.

C. Grace Period

Except for your first premium, any premium not paid to us by the due date is in default. However, there is a grace period beginning with the first day of the payment period during which you fail to pay the premium. The grace period is 10 days after the first day of the payment period. This Policy's coverage will remain in force during the grace period. If you don't pay your premium within the applicable grace period, this Policy shall automatically terminate on the last day of the applicable grace period at 11:59 p.m. You are required to pay for coverage we provide during that grace period.

D. Coverage Period

The *coverage period* under this Policy is shown in your completed application for coverage. This Policy shall be in force for the *coverage period* commencing at 12:00 a.m. on the effective date shown in your completed application for coverage, provided that the premium shall first have been pre-paid to and accepted by WPS. This Policy shall terminate automatically without notice on the date shown in your completed application for coverage.

This policy is not renewable. During this Policy's *coverage period* this policy cannot be canceled by us or the customer, except as stated in Section VIII. (When Coverage Ends). Premium payments cannot be refunded after this policy is issued to the customer, except as stated in Sections X. E. (General Provisions / Age Limitations) and X. N. (General Provisions / Incontestability).

E. Reinstatement (after Policy termination for nonpayment of Premium)

In certain circumstances, you may be able to reinstate your coverage if your Policy is terminated because you did not pay your premium.

If you send us a premium payment, and we accept your payment, your coverage will be reinstated as of the date we accept your payment. You must send this payment within 15 days of the date your Policy was terminated. We will notify you within 45 days of receiving your payment if we accept.

We will only allow you to reinstate this Policy one time per *coverage period*.

X. GENERAL PROVISIONS

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

We won't interfere with the professional relationship you have with your *health care practitioner, hospital* or other *health care provider*. We do not require that you choose any particular *health care practitioner, hospital, or other health care provider*, although there may be different *benefits* payable under the Policy depending on your choice of *health care practitioner, hospital, or other health care provider*. We do not guarantee the competence of any particular *health care practitioner, hospital, other health care provider* or their availability to provide services to you. You must choose the *health care practitioner, hospital, or other health care provider* you would like to see and the *health care services* you wish to receive. We're not responsible for any *injury, damage or expense* (including attorneys' fees) you suffer as a result of any improper advice, action or omission on the part of any *health care practitioner, hospital, or other health care provider*, including, but not limited to, any *preferred provider*. We're obligated only to provide the *benefits* as specifically stated in the Policy.

B. Your Right to Choose Medical Care

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

C. Health Care Practitioner, Hospital or Other Health Care Provider Reports

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

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

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

D. Assignment of Benefits

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

E. Age Limitations

The maximum age for an applicant or his/her spouse on the effective date of this policy is age 64 and for each dependent child is age 25. If this policy is issued to an applicant who is over age 64 at the time this policy is issued to him/her this policy is null and void and this policy must be surrendered immediately by the applicant to us. We will return the premium paid by that applicant less the amount of claims paid, if any. If the applicant's spouse is over age 64, or a dependent child is over age 25, at the time this policy is issued to the applicant, that spouse's or child's coverage is null and void. We will return the premium paid by the applicant less the amount of claims paid, if any.

F. Subrogation

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

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

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

1. Sign and deliver all necessary papers we reasonably request to protect or enforce our rights;
2. Do whatever else is necessary to protect or allow us to enforce our rights including joining us as a party as we may request when you have commenced a legal action to recover for a personal *injury*; and
3. Not do anything before or after our payment that would prejudice our rights.

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

the question of whether or not you have been made whole, we reserve the right to seek a judicial determination of whether or not you have been made whole.

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

G. Limitation on Lawsuits and Legal Proceedings

By accepting coverage under the Policy, you agree that you will not bring any legal action against us regarding *benefits*, claims submitted, the payment of *benefits* or any other matter concerning your coverage until the earlier of: (1) 60 days after we have received the claim described in Section XI. B. (Claim Filing and Processing Procedures / Filing Claims); or (2) the date we deny payment of *benefits* for a claim. This provision does not apply if waiting will result in loss or *injury* to you. However, the mere fact that you must wait until the earlier of the above dates does not alone constitute loss or *injury*.

By accepting coverage under the Policy, you also agree that you will not bring any legal action against us more than three years after the claim filing deadline outlined in Section XI. B. (Claim Filing and Processing Procedures / Filing Claims).

H. Severability

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

I. Conformity with Applicable Laws and Regulations

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

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

K. Refund Requests

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

L. Quality Improvement

The WPS Quality Improvement Committee evaluates and monitors key aspects of service and health care provided to *covered persons*. The Medical Director directs the Quality Improvement Committee. Various committees consisting of

preferred providers and WPS staff guide, direct, and evaluate quality initiatives. *Preferred providers* are evaluated using nationally accepted criteria prior to joining the network and are reevaluated every three years thereafter.

M. Your Rights and Responsibilities

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

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

1. Your Rights as a Health Plan Member

- a. You have the right to receive quality health care that's friendly and timely.
- b. You have the right to be treated with respect and recognition of your dignity and right to privacy.
- c. You have the right to receive all medically necessary covered services when your health care providers feel they are needed.
- d. You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- e. You have the right to refuse treatment.
- f. You have the right to participate with health care providers in making decisions about your health care.
- g. You have the right to all information contained in your medical records.
- h. You have the right to receive information about us, our services, and our network of health care providers as well as your rights and responsibilities.
- i. You have the right to make a list of instructions about your health care treatments (called a living will) and to name the person who can make health care decisions for you.
- j. You have the right to have your medical and financial records kept private.
- k. You have the right to voice complaints or appeals about us or the health care coverage we provide.
- l. You have the right to have a resource at WPS that you can contact with any concerns about services and to receive a prompt and fair review of your complaint.
- m. You have the right to make recommendations regarding the member rights and responsibilities policies.

2. Your Responsibilities as a Health Plan Member

- a. You have the responsibility to select a health care practitioner and to communicate with him or her in order to develop a patient- health care practitioners relationship based on trust, respect, and cooperation.
- b. You have the responsibility to know your health plan benefits and requirements.
- c. You have the responsibility to coordinate all non-life-threatening care through your health care practitioner.
- d. You have the responsibility to review your insurance information upon enrollment and to ask questions to verify that you understand the procedures and explanations that are given.
- e. You have the responsibility to supply information (to the extent possible) that health care providers need in order to provide care and that we need in order to provide coverage.
- f. You have the responsibility to understand your health problems and to participate in developing mutually agreed-upon treatment goals to the degree possible.
- g. You have the responsibility to follow the treatment plan and instructions for care that have been agreed on with your health care practitioners.

- h. You have the responsibility to give proof of coverage each time you receive services and to update your clinic with any personal changes.
- i. You have the responsibility to pay copayments when you receive services and to promptly pay deductibles, coinsurance, and other charges for services not covered by the Policy.
- j. You have the responsibility to keep appointments for care or to give early notice if you need to cancel.

N. Incontestability

All statements made in an application or supplemental applications, if any, are representations, not warranties. No statement shall be used by us to: (1) contest or void coverage under this Policy; (2) reduce, limit or deny payment of *benefits* under this Policy; or (3) defend a claim under this Policy; unless such statement is in writing, a copy of which is supplied to the *subscriber*.

We will not reduce or deny a claim for an *illness* or *injury* commencing 12 months from the date of issue of this Policy on the ground that the *illness* or *injury* existed prior to the effective date of coverage.

We will reduce the length of time during which a pre-existing condition exclusion may be imposed by the aggregate of your consecutive coverage periods under this Policy. Coverage periods are consecutive if there are no more than 63 days between coverage periods. See the definition of *pre-existing illness or injury* in Section XIV. (Definitions) and Exclusion C. in Section VI. (General Exclusions).

O. Misstatement of Age

Age means your age on your last birthday. If your age has been misstated, we will make an equitable adjustment to your premiums and/or *benefits*, as permitted by law.

P. Written Notice

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

XI. CLAIM FILING AND PROCESSING PROCEDURES

A. Definitions

1. **Concurrent Care Decision:** a decision by us to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by us or a decision with respect to a request by you to extend a course of treatment beyond the period of time or number of treatments that has been approved by us.
2. **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.
3. **Incomplete Claim:** a correctly filed claim that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, and subrogation questionnaire.
4. **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.
5. **Post-Service Claim:** any claim for a benefit under the Policy that is not a pre-service claim.
6. **Pre-Service Claim:** any claim for a benefit with respect to which the terms of the Policy condition receipt of a benefit, in whole or in part, on receiving prior authorization before obtaining medical care.
7. **Urgent Claim:** any *pre-service claim* for medical care or *treatment* with respect to which the application of the time periods for making non-*urgent care* determinations could seriously jeopardize the life or health of the

claimant or the ability of the claimant to regain maximum function or in the opinion of a *health care practitioner* with actual knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or *treatment* that is the subject of the claim.

B. Filing Claims

1. How to File a Claim

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

- a. A fully-completed claim form, including all of the following information:
 - 1) Subscriber name;
 - 2) Subscriber number;
 - 3) Provider name;
 - 4) Provider address;
 - 5) Provider Tax ID or National Provider Identifier (NPI) Number;
 - 6) Patient's name;
 - 7) Patient's date of birth;
 - 8) Date of service;
 - 9) Procedure code;
 - 10) Diagnosis code; and
 - 11) Billed *charges* for each service.
- b. If all sections of the claim form are not completed in full, your claim may be returned to you.
- c. Proof of payment.

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

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

2. Exception to 90-Day Claim Filing Deadline

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

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

3. Pharmacy Prescription Claims

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

4. How to Appeal a Claim Denial

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

C. Designating an Authorized Representative

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

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

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

If you have an *authorized representative*, any references to “you” or “your” in this Section XI. will refer to the *authorized representative*.

D. Claim Processing Procedure

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

1. **Concurrent Care Decisions.** We will notify you of a *concurrent care decision* that involves a reduction in or termination of *benefits* prior to the end of any *prior authorized* course of *treatment*. The notice will provide time for you to file a *grievance* and receive a decision on that *grievance* prior to the *benefit* being reduced or terminated. This will not apply if the *benefit* is reduced or terminated due to a *benefit* change or termination of the Policy.

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

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

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

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

If the claim is an *incomplete claim*, we will notify you of the specific information needed as soon as possible, but no later than 24 hours after we receive the *incomplete claim*. You will then have 48 hours from the receipt of the notice to provide us with the requested information. We will notify you of our decision as soon as possible, but

not later than 48 hours after the earlier of: (a) our receipt of the additional information; or (b) the end of the period of time provided to submit the additional information.

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

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

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

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

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

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

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

E. Claim Decisions

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

If the claim is denied in whole or in part, you will receive a written notice from us within the time frames described above. However, notices of *adverse benefit determinations* involving an *urgent claim* may be provided to you verbally within the time frames described above for expedited claim decisions. If verbal notice is given under such circumstances, then written notification will be provided to you no later than 3 days after the verbal notification.

A denial notice will state the specific reason or reasons for the *adverse benefit determination*, the specific Policy provisions on which the determination is based, and a description of the internal and external review procedures and associated timelines. The notice will include a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

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

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

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

XII. INTERNAL GRIEVANCE AND APPEALS PROCEDURES

A. General Grievance Information

Situations might occasionally arise when you question or are unhappy with our claims decision or some aspect of service that you received from us. We can resolve most of your concerns without you having to file a *grievance*. Therefore, before filing a *grievance*, we urge you to speak with our Customer Service Department to try to resolve any problem, question, or concern that you have by calling the telephone number on your identification card. A customer service representative will record your information and your proposed resolution and consider all information that we have about your concern. If necessary, he/she will then discuss the matter with a supervisor in our Customer Service Department.

We will respond to your proposed resolution in writing by sending you a letter or an Explanation of *Benefits* that explains the actions we have taken to resolve the matter. If the matter cannot be informally resolved, you have the right to file a *grievance* in writing with our Grievance/Appeal Committee in accordance with the procedure described below.

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

B. Grievance Procedures

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

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

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

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

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

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

As soon as reasonably possible after we receive your *grievance*, our Grievance/Appeal Department will review the information you provided and consider your proposed resolution in the context of any information we have available about the applicable terms, conditions, and provisions of the Policy. If we agree with your proposed resolution, we will notify you by sending a letter explaining our subsequent claims processing action or administrative action that resolves the matter to your satisfaction. If our Grievance/Appeal Department upholds the original claims processing or administrative decision that you challenged, the *grievance* will be automatically forwarded to our Grievance/Appeal Committee (the "Committee") for its review and decision in accordance with the *grievance* procedure explained further below.

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

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

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

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

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

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

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

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

1. **Pre-Service Claims.** We will notify you of our final decision as soon as possible, but not later than 30 days after our receipt of your *grievance* for a *pre-service claim*.
2. **Post-Service Claims.** We will notify you of our final decision as soon as possible, but not later than 60 days after our receipt of your *grievance* for a *post-service claim*.
3. **Concurrent Care.** We will notify you of our final decision to reduce or terminate an initially approved course of *treatment* before the proposed reduction or termination takes place. We shall decide the appeal of a denied request to extend any *concurrent care decision* in the appeal time frame for a *pre-service claim*, *urgent claim*, or a *post-service claim*, as appropriate to the request.
4. **Expedited Grievances.** We will notify you of our final decision as soon as possible, but not later than 72 hours after receipt of the *expedited grievance*. An *expedited grievance* includes an appeal of an *urgent claim*.

C. Expedited Grievance Procedure

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

WPS Health Insurance
 Grievance and Appeals Department
 P. O. Box 7062
 1717 West Broadway
 Madison, Wisconsin 53707-7062
 Phone: (800) 332-6421 (toll-free)
 Fax Number: (608) 327-6319

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

Any *expedited grievance* filed by your *health care practitioner* regarding a *prescription legend drug* or *durable medical equipment* or a medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay *benefits* for that *prescription legend drug*, *durable medical equipment* or medical device that is not covered under the Policy.

As soon as reasonably possible following our receipt of the *expedited grievance*, our Grievance/Appeal Department will review the *expedited grievance*. If we agree with the proposed resolution of this matter, we will contact you by phone or fax to explain our decision and then follow up with either a letter or an Explanation of *Benefits* form explaining how we resolved your *expedited grievance*. If our Grievance/Appeal Department upholds our original claims processing decision or administrative decision that you disputed, the *expedited grievance* will be automatically forwarded to our Grievance/Appeal Committee (the "Committee") for its review and decision in accordance with the procedure explained below. Under no circumstances will the time frame exceed the time period discussed below.

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

You also have a right to appear in person or to participate by teleconference before the Committee to present information to the Committee and to submit written questions to the Committee. The Committee will respond to any submitted written question in its notice to you of its final *benefit* determination. We will notify you of the time and place of the meeting as soon as reasonably possible. Please remember that this meeting is not a trial where there are rules of evidence are followed. Also, cross-examination of the Committee's members, its advisors, or WPS employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the Committee. However, your presentation to

the Committee will be recorded. If you attend the meeting to present reason(s) for the *expedited grievance*, we expect and require each person who attends the meeting to follow and abide by our established internal practices, rules and requirements for handling *expedited grievances* effectively and efficiently in accordance with applicable laws and regulations.

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

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

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

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

As expeditiously as your health condition requires, but not later than 72 hours after our receipt of the *expedited grievance*, the Grievance/Appeal Department will contact you by phone or fax to explain the Committee's rationale and decision. Not later than 3 days following, the Committee will then mail a detailed decision letter containing all information required by law. The letter will be mailed to the person who filed the *expedited grievance* using the United States Postal Service.

A notice of a final *adverse benefit determination* will state the specific reason or reasons for the final *adverse benefit determination*, the specific Policy provisions on which the determination is based, and a description of the external review procedures and associated timelines. The notice will include a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

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

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

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

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

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

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

D. Final Claim Decisions

A notice of a final *adverse benefit determination* will state the specific reason or reasons for the final *adverse benefit determination*, the specific Policy provisions on which the determination is based, and a description of the external review procedures and associated timelines. The notice will include a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

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

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

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

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

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

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

XIII. INDEPENDENT REVIEW

A. Definitions

The following definitions apply to this Section XIII. only:

1. **Adverse Determination:** a determination by WPS to which all of the following apply:
 - a. We have reviewed admission to a health care facility, the availability of care, the continued stay or other *treatment*;
 - b. Based on the information provided, the *treatment* does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; and
 - c. Based on the information provided, we reduced, denied or terminated the *treatment* or payment of the *treatment*.

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

2. **Experimental Treatment Determination:** a determination by WPS to which all of the following apply:
 - a. We have reviewed the proposed *treatment*;
 - b. Based on the information provided, we have determined the *treatment* is *experimental/ investigational/ unproven*; and
 - c. Based on the information provided, we denied the *treatment* or payment for the *treatment*.

B. Independent Review Process

The independent review process provides you with an opportunity to have an independent review organization (IRO) that is approved and certified by the Wisconsin Office of the Commissioner of Insurance (OCI) review your dispute. For a listing of the IRO's, please contact us at the telephone number shown on your Identification Card.

You can request an independent review if you have received an *experimental treatment determination* or an *adverse determination*. In addition, the total cost of the denied coverage must exceed \$348. The *health care service* must be covered under the Policy. Benefits specifically excluded from the Policy are not eligible for independent review. Pursuant to Wisconsin Statute 632.835(3)(f), a decision of an IRO is binding on the *covered person* and the insurer.

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

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

Your request for an independent review must include:

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

You must complete our internal *grievance* procedure before requesting an independent review. However, you do not need to complete this process if you and us agree to proceed directly to independent review or if you feel that you need immediate medical care. If you need immediate medical treatment and you believe that the time period for resolving an internal *grievance* will cause a delay that could jeopardize your life or health, you may ask to bypass our internal *grievance* process. To do this, send your request to the IRO at the same time you send your request to us. The IRO will review your request and decide if an immediate review is needed. If so, the IRO will review your dispute on an expedited basis. If the IRO determines that your health condition does not require its immediate review of your dispute, it will notify you that you must first complete the internal *grievance* process provided by us.

After receiving your request for an independent review along with the required information listed in 1. thru 5. above, we will forward all relevant medical records and other documentation used in making our decision to the IRO of your choice within five business days. The IRO then has five business days to review the information and to request any additional information it may need from you or us. After receiving all necessary information, the IRO will make a final, binding determination within 30 business days. If the IRO determines that this time period could jeopardize your life or health, we will send all documents within one day and the IRO will then have two business days to request additional information. The IRO will then make a final, binding decision within 72 hours. All of the information provided by you and us, as the insurer, is reviewed by a clinical peer reviewer.

The IRO and its reviewer are required to consider all of the documentation, including your medical records, your attending provider's recommendation, the terms of the coverage of your health plan, the rationale for our prior decision and any medical or scientific evidence. In addition, some of the information you provide may be shared with the OCI.

For more information on your IRO rights or to receive an updated copy of Independent Review Organizations available to you, please contact us at the address and telephone number shown on your identification card or visit our website at wpshealth.com.

XIV. DEFINITIONS

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

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

- A. Bathing which is the cleansing of the body in either a tub or shower or by sponge bath;
- B. Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- C. Toileting which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
- D. Mobility, which is to move from one place to another, with or without assistance of equipment;
- E. Eating, which is getting nourishment into the body by any means other than intravenous; and
- F. Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

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

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

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

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 Policy, the Schedule of Benefits and any attached endorsements.

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

Child/Children: any of the following:

- A. A biological *child* of a *subscriber*.
- B. A step-child of a *subscriber*.
- C. A legally adopted child or a child placed for adoption with the *subscriber*.
- D. A *child* under the *subscriber's* (or his/her spouse's) legal guardianship as ordered by a court. To be initially eligible for coverage, the *child* must be under the age of 18 and you must have sole and permanent guardianship of both the *child* and his/her estate. See Section II. C. (Special Enrollment Options / Court Order).

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

Complication of Pregnancy: a condition with a diagnosis that is distinct from pregnancy, but is adversely affected by pregnancy or caused by pregnancy, such as:

- A. Acute nephritis;
- B. Nephrosis;

- C. Cardiac decompensation;
- D. Hyperemesis gravidarum;
- E. Puerperal infection;
- F. Pre-Eclampsia (toxemia);
- G. Eclampsia;
- H. Abruptio placentae;
- I. Placenta previa;
- J. Missed or threatened abortions;
- K. Ectopic pregnancy;
- L. Endometritis;
- M. Hydatidiform mole;
- N. Chorionic carcinoma;
- O. Pre-term labor;
- P. Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible;
or
- Q. Gestational diabetes.

Complication of pregnancy does not include false labor, occasional spotting, rest prescribed during period of pregnancy, elective Caesarean section, or a high-risk pregnancy.

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

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

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

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.

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

Coverage Period: the period of time commencing at 12:00 a.m. on the effective date of coverage and ending at 11:59 p.m. on the termination date as stated in your completed application for coverage as determined by us;

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:

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

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

- A. You are under the care of a *health care practitioner*;
- B. The *health care practitioner* prescribes *health care services* to support and maintain your physical and/or mental condition;
- C. Services are being provided by a nurse; or
- D. 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 *coverage period* before *benefits* are payable under the Policy. This defined term does not include a *drug deductible* as defined in Section V. Z. (Covered Expenses / Prescription Legend Drugs and Supplies).

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

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

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

Eligible Dependent: a citizen of the United States or a resident legal alien who falls into one or more of the five categories below and who is not on active military duty for longer than 30 days:

- A. A *subscriber's* legal spouse.
- B. A *subscriber's child*, under the age of 26.
- C. A *full-time student returning from military duty*.
- D. A *subscriber's child* over age 26 if all of the following criteria are met:
 - 1. The *child's* coverage under the Policy began before he/she reached age 26;
 - 2. The *child* is incapable of self-sustaining employment because of intellectual disability or physical handicap;
 - 3. The *child* is chiefly dependent upon the *subscriber* for support and maintenance;

4. The *child's* incapacity existed before he/she reached age 26; and
5. The *subscriber's family coverage* remains in force under the Policy.

E. A biological child of a *subscriber's child* if the *subscriber's child* is under 18 years old.

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

Emergency Room Visit: a meeting between you and a *health care practitioner* that: (1) occurs at the emergency room; and (2) includes only the *charges* for the emergency room fee billed by the *facility* for use of the emergency room.

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

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

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

- A. It is not currently recognized as accepted medical practice;
- B. It was not recognized as accepted medical practice at the time the *charges* were incurred;
- C. It has not been approved by the United States Food and Drug Administration (FDA) upon completion of Phase III clinical investigation;
- D. It is being used in a way that is not approved by the FDA or listed in the FDA-approved labeling (*i.e.* off-label use), except for off-label uses that are accepted medical practice);
- E. It has not successfully completed all phases of clinical trials, unless required by law;
- F. It is based upon or similar to a treatment protocol used in on-going clinical trials;
- G. Prevailing peer-reviewed medical literature in the United States has failed to demonstrate that it is safe and effective for your condition;
- H. There is not enough scientific evidence to demonstrate or make a convincing argument that (a) it can measure or alter the sought-after changes to your *illness* or *injury* or (b) such measurement or alteration will affect your health outcome; or support conclusions concerning the effect of the drug, device, procedure, service or *treatment* on health outcomes; or
- I. It is associated with a Category III CPT code developed by the American Medical Association.

The above list is not all-inclusive.

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

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

Family Coverage: coverage that applies to a *subscriber* and his/her *covered dependents*.

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

Full-Time Student Returning From Military Duty: an adult *child* of a *subscriber* who meets all of the following criteria:

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

Additionally, the adult *child* must: (1) attend an accredited school for the number of credits, hours, or courses required by the school to be considered a *full-time student*; (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his/her degree. The adult *child* continues to be a *full-time student* during periods of vacation or between term periods established by the school.

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

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

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

Grievance: any dissatisfaction with us or our administration of your health *benefit plan* that you express to us in writing. For example, you might file a *grievance* about our provision of services, our determination to reform or rescind a policy, our determination of a diagnosis or level of service required for *evidence-based treatment* of *autism spectrum disorders*, or our claims practices.

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

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

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

Health Care Services: diagnosis, *treatment, hospital services, surgical services* as defined in Section V. FF. (Covered Expenses / Surgical Services), *medical services, procedures, drugs, medicines, devices, supplies, or any other service* directly provided to you by a *health care provider*.

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

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

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

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. *Illness* includes *complication of pregnancy*. *Illness* does not include *substance use disorders* or *nervous or mental disorders*.

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

Infertility or Fertility Treatment: a *health care service* that is intended to: (1) promote or preserve fertility; or (2) achieve and maintain a condition of pregnancy. For purposes of this definition, *infertility or fertility treatment* includes, but is not limited to:

- A. Fertility tests and drugs;
- B. Tests and exams done to prepare for or follow through with induced conception;
- C. Surgical reversal of a sterilized state that was a result of a previous surgery;
- D. Sperm enhancement procedures; and
- E. Direct attempts to cause or maintain pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; GIFT or ZIFT; embryo transfer; and freezing or storage of embryo, eggs, or semen.

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

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

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

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

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

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

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

- A. Serious jeopardy to a person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn *child*;
- B. Serious impairment to a person's bodily functions; or
- C. Serious dysfunction of one or more of a person's body organs or parts.

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

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

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

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

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

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

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

Non-Preferred Provider: a *health care provider* that has not entered into a written agreement with the health care network selected by the *subscriber* or *covered person* as of the date upon which the services are provided.

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

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

Office Visit: A meeting between you and a *health care practitioner* that: (a) occurs at the *health care practitioner's* office, a medical clinic, *convenient care clinic*, an ambulatory surgical center, a free-standing *urgent care* center, *skilled nursing facility*, the outpatient department of a *hospital* other than an emergency room, in your home, or via telephone or interactive audio-video telecommunication; and (b) includes you receiving medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology or as determined by us) .

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

- A. Support, align, prevent, or correct deformities.
- B. Improve the function of movable parts of the body.
- C. Limit or stop motion of a weak or diseased body part.

Out-of-Pocket Limit: the maximum amount that you are required to pay each *coverage period* for *covered expenses*. This limit is shown in the Schedule of Benefits. In determining whether you've reached your *out-of-pocket limit*, amounts such as: (1) amounts you pay for non-covered *health care services*; (2) amounts you pay that exceed the *maximum allowable fee* and (3) amounts you pay for the difference between the brand-name drug and the lower cost equivalent drug (*generic* or *biosimilar*) will not count towards your *out-of-pocket limit*.

Physician: a person who:

- A. Received one of the following degrees in medicine from an accredited college or university: Doctor of Medicine (M.D.); Doctor of Osteopathy (D.O); Doctor of Dental Surgery (D.D.S); Doctor of Dental Medicine (D.D.M.); Doctor of Podiatric Medicine (D.P.M.); Doctor of Optometry (O.D.); or Doctor of Chiropractic (D.C.);
- B. Is a medical doctor or surgeon holding a license or certificate of registration from the medical examining board in the state in which he/she is located; and
- C. Practices medicine within the lawful scope of his/her license.

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

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

Pre-existing Illness or Injury: Five years prior to your effective date of coverage, you may have: (1) had an *illness* or *injury* diagnosed or (2) received care or medical services or treatment for an *illness* or *injury*.

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

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

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

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

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

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.

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

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

Skilled Nursing Care: *health care services* that: (1) are furnished pursuant to a *health care practitioner's* orders; (2) require the skills of professional personnel such as a registered nurse or a licensed practical nurse; and (3) are provided either directly by or under the direct supervision of such professional personnel. Patients receiving *skilled nursing care* are usually quite ill and often have been recently hospitalized. In the majority of cases, *skilled nursing care* is only necessary for a limited time period. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, *children*, or other family or relatives. The following examples are generally considered care that can be provided by "nonskilled" persons, and therefore do not qualify as *skilled nursing care*: range of motion exercises, strengthening

exercises, simple wound care, ostomy care, tube and gastrostomy feedings, administration of basic medications, maintenance of urinary catheters, assistance with performing *activities of daily living*, and supervision for potentially unsafe behavior.

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

- A. Is operating pursuant to state and federal law;
- B. Is under the full-time supervision of a *health care practitioner* or registered nurse;
- C. Provides services seven days a week, 24 hours a day, including *skilled nursing care* and therapies for the recovery of health or physical strength;
- D. Is not a place primarily for custodial or *maintenance care*;
- E. Requires compensation from its patients;
- F. Admits patients only upon a *health care practitioner's* order;
- G. Has an agreement to have a *health care practitioner's* services available when needed;
- H. Maintains adequate records for all patients; and
- I. Has a written transfer agreement with at least one *hospital*.

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

Subscriber: an individual who: (1) is a citizen of the United States or a resident legal alien; (2) has been properly enrolled and approved for coverage under this Policy; (3) has paid the appropriate premium in accordance with this Policy; and (4) has been issued an identification card from WPS identifying him/her as the *subscriber*.

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

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

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

Surgical Services: (1) an operative procedure performed by a *health care practitioner* that we recognize as *treatment* of an *illness* or *injury*; or (2) those services we identify as *surgical services*.

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

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

XV. WISCONSIN DEPARTMENT OF INSURANCE CONTACT INFORMATION

You may resolve your problem by taking the steps outlined in Sections XI. (Claim Filing and Processing Procedures), XII. (Internal Grievance and Appeal Procedures), and XIII. (Independent Review).

You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint.

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

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

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