Aspirus Health Plan, Inc.
3000 Westhill Drive, Suite 303, P.O. Box 395, Wausau, WI 54402

INDIVIDUAL HMO SILVER 0 CSR 94 CONTRACT

This is *your contract* while *you* are covered. It explains *your* rights and benefits under this *contract*. This *contract* is a legal contract between *you* and *us*. All coverage under this *contract* begins at 12:01 AM Central Time.

This *contract* along with any amendments and *your* application constitutes the entire agreement under which payments are made. *We* will pay the benefits set forth in this *contract*. Benefit payment is governed by all the terms, conditions, and limitations of this *contract*. This *contract* may be amended at any time without *your* consent. Notice will be provided at least 30 calendar days in advance of any amendment taking effect. Any such amendment will not affect a claim starting before the amendment takes effect. This *contract* has been issued and delivered to *you* in Wisconsin. Except as otherwise stated in this *contract*, this *contract* will be governed by federal law and the laws of Wisconsin.

This *contract* was issued on the basis that the information on *your* application was correct and complete. If any of this information provided was not correct, write to *us* within ten calendar days of receipt of this *contract*. An error or omission on *your* application or in *your* enrollment process, as applicable, may cause *us* to ask *you* to pay an increased *premium*. If *you* misstate *your* age or make other unintentional errors, *we* will refund overpayments or collect the balance due based on *your* correct age. *We* can rescind *your* coverage for intentional misrepresentation of a material fact or fraud. After *your* coverage under this *contract* is validly in effect, its validity cannot be contested unless *you* (or anyone seeking coverage on *your* or *your dependent's* behalf, including a personal representative) performed an act, practice, or omission that constitutes fraud, or *you* or *your dependent* made an intentional misrepresentation of material fact (including a misleading omission of material fact). "Material facts" may include, for example, statements or omissions on the application or in the enrollment process, as applicable, made as part of *your* enrollment and claims for coverage or reimbursement that misrepresent an individual's continuing status as a *dependent*.

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

Your* Right to Return This *Contract. Please read this *contract* right away. If *you* are not satisfied with this *contract* 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 *contract* and refund all premium payments that *you* have made to *us* for it. The *contract* will become null and void and no coverage will be provided to *you* under it.

ACCEPTANCE OF THIS *CONTRACT*. Except as provided in the preceding paragraph, *our* receipt of the full amount due for *your* first monthly premium will signify *your* acceptance of all terms, conditions, and obligations of this *contract*. Acceptance will be effective on the *effective date* of this *contract*.

READ *YOUR CONTRACT* CAREFULLY.

THIS POLICY IS RENEWABLE WITH CONSENT OF ASPIRUS HEALTH PLAN, INC.

IN WITNESS WHEREOF, *our* President hereby signs this *contract*.

Brett H. Davis
President

Customer Service	
Questions?	***Our* Customer Service staff is available to answer questions about *your* coverage Monday through Friday, 7 AM – 7 PM Central Time** **When contacting *us*, please have *your member* identification card available. If *your* questions involve a claim, *we* will need to know the date of service, type of service, the name of the *provider*, and the charges involved.**
Telephone Numbers:	**Monday through Friday 7 AM - 7 PM Central Time** **Toll free .....1.866.631.4611** **Fax.....763.847.4400** **Hearing impaired individuals 1.866.631.8597**
Website:	**www.aspirushealthplan.com**
Mailing Address:	**Notice of claims, proof of loss, review requests, prior authorization, and written inquiries may be mailed to:** **Customer Services Department** **Aspirus Health Plan, Inc.** **PO Box 1062** **Minneapolis, MN 55440**

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. *We* do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We will:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If *you* need these services, contact *us* at the phone number shown on the inside cover of this *contract*, *your* id card, or aspirushealthplan.com.

If *you* believe that *we* have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1. 866.631.4611 (TTY: 763.847.4013)
Fax: 763.847.4400
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help *you*.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1-800-332-6501 (TTY: 711).

Arabic تنبيه :إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف 1-800-332-6501(رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1-800-332-6501 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1-800-332-6501 (TTY: 711).

Hindi: _यान द_: य_द आप ंहदी बोलते ह_ तो आपके लए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_।1-800-332-6501 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-332-6501 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-800-332-6501 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-6501 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1-800-332-6501 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al1-800-332-6501 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-800-332-6501 (TTY: 711).

Traditional Chinese: 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請 致電 1-800-332-6501 TTY：711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-6501 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-332-6501 (TTY: 711).

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I. Important *Member* Information

Contract Year. *Your* first contract year begins on the *effective date* of *your* coverage and ends on December 31 of that *calendar year*. Subsequent contract years run on a *calendar year* basis, January 1 through December 31.

Covered Services. This *contract* defines what services are covered by *us* and describes procedures *you* must follow to obtain coverage.

Essential Health Benefits. This *contract* covers all *essential health benefits. Essential health benefits* are subject to some limitations or exclusions under this *contract*.

Exclusions. Certain services or medical supplies are not covered. *You* should read this *contract* for detailed explanation of all exclusions.

Providers. Enrolling under this *contract* does not guarantee services by a particular *provider* on the list of *providers*. Except as provided in the "Continuity of Care" provision of this *contract*, when a *provider* is no longer a *participating provider* with *us*, *you* must choose among remaining *participating providers*. Contact Customer Service for the most recent listing of *participating providers* or for information about continuity of care.

Wellness. *We* may offer and provide wellness and fitness incentives to *you* in connection with services received from *us* or designated third party vendors.

II. *Member* Rights and Responsibilities

As *our member*, *you* have the following rights and responsibilities:

1. A right to receive information about *us*, *our* services, *our participating providers* and *your member* rights and responsibilities.
2. A right to be treated with respect and recognition of *your* dignity and right to privacy.
3. A right to available and accessible services, including *emergency services*, 24 hours a day, 7 days a week.
4. A right to be informed of *your* health problems and to receive information regarding treatment alternatives and risks that are sufficient to assure informed choice.
5. A right to participate with *providers* in making decisions about *your* health care.
6. A right to a candid discussion of appropriate or *medically necessary* treatment options for *your* conditions, regardless of cost or benefit coverage.
7. A right to refuse treatment.
8. A right to privacy of medical, dental and financial records maintained by *us* and *our participating providers* in accordance with existing law.
9. A right to voice complaints and/or appeals about *our* policies and procedures or care provided by *participating providers.*
10. A right to file a complaint with *us* and the Wisconsin Office of the Commissioner of Insurance and to initiate a legal proceeding when experiencing a problem with *us.* For information, contact the Wisconsin Office of the Commissioner of Insurance at 608.266.0103 or 1.800.236.8517 and request information.
11. A right to make recommendations regarding *our member* rights and responsibilities policies.
12. A responsibility to supply information (to the extent possible) that *participating providers* need in order to provide care.
13. A responsibility to supply information (to the extent possible) that *we* require for health plan processes such as enrollment, claims payment and benefit management, and providing access to care.
14. A responsibility to understand *your* health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
15. A responsibility to follow plans and instructions for care that *you* have agreed on with *your providers*.
16. A responsibility to advise *us* of any discounts or financial arrangements between *you* and a *provider* or manufacturer for *health care services* that alter the charges *you* pay.

III. Disclosure of *Provider* Payments

Participating providers submit claims for *eligible charges* to *us* with their usual charge for the *health care services*. *Your* benefits are determined based on the service and the claims' *eligible charges* that are paid according to the applicable *fee schedule*. This may be based on various methodologies, depending on the *provider* type and contract (i.e. per service, per

event, per day, by diagnostic related group or percent of charge). The *deductible* and *coinsurance* amounts are based on the *fee schedule* amount.

Post-service claims submitted to *us* for *non-participating provider benefits* are paid on a *fee-for-service* basis. *We* determine *your* benefits based on the *non-participating provider reimbursement value*.

We do not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization. Utilization management decision making is based only on appropriateness of care and service and existence of coverage.

IV. *Member* Information for *Non-Participating Provider Benefits*

Covered Services. *We* cover specified services from *non-participating providers* at varying levels of coverage. *Deductibles, coinsurance, copayments* and maximum benefit restrictions may apply. This *contract* lists the services available and describes the procedures for receiving coverage through *non-participating providers*.

Prior Authorization. The section entitled "Prior Authorization Recommendation" in this *contract* explains prior authorization requirements.

V. General Provisions

A. Introduction to *Your* Coverage

This *contract* describes *your* health care coverage with *us*. *We* may not cover all of *your* health care expenses. Read this *contract* carefully to determine which expenses are covered. *We* have discretionary authority to determine eligibility for benefits under this *contract* and to interpret and construe terms, conditions, limitations, and exclusions of this *contract*. Many provisions are interrelated; therefore, reading just one or two provisions may not give *you* a complete understanding of the coverage described under this *contract*. Italicized words used in this *contract* have special meanings and are defined at the back of this *contract*.

B. Non-*Emergency Services* Received in a *Participating Provider* Facility from a *Non-Participating Provider*

If a *participating provider* arranges and/or performs services for *you* at a *participating provider* facility, all related eligible non-facility charges from both *participating providers* and *non-participating providers* are covered at the *participating provider* level of benefits as shown in the "Description of Benefits."

If a *non-participating provider* arranges or performs services for *you* at a *participating provider* facility with *your* written authorization, all related eligible non-facility charges from any *non-participating providers* are covered at the *non-participating provider* level of benefits, if any, as described in the "Description of Benefits.

C. Continuity of Care

If a *participating provider* leaves *our* network, *you* may, under the following circumstances, continue to receive care from that *provider* at the *participating provider benefit* level for a designated period of time. The continuity of care provisions outlined below do not apply when: (1) the *provider* no longer practices within the *geographical service area*; or (2) the *provider's* participation with *us* is terminated because of their misconduct.

1. ***Primary Care Practitioner (PCP).*** *We* will continue to cover *health care services* provided by a *participating provider* who is a *primary care practitioner* until the end of the *calendar year* for which *we* represented that the *provider* was, or would be, a *participating provider*.
2. **Other than *PCP* Participating *Providers*.** If *you* are undergoing a course of treatment with a *participating provider*, other than a *PCP*, *we* will continue to cover *health care services* from that *participating provider* for the following period of time, whichever is shorter: (a) for the remainder of the course of treatment; or (b) for 90 days after the participation in *our* network terminates.
3. **Maternity Services.** *We* will continue to cover services for a *member* who is in the second or third trimester of pregnancy until the completion of postpartum care for the *member* and the infant.

D. Referrals and Open Access

Your provider may suggest that *you* receive a *health care service* from a specific *provider* or receive a specific *health care service*. Even though *your provider* may recommend or provide written authorization for a referral for certain *health care services*, the *provider* where *you* receive the *health care services* may be a *non-participating provider* or

the recommended *health care service* may be covered at a lesser level of benefits or be specifically excluded. When these *health care services* are referred or recommended, a written authorization from *your provider* does not override any specific network requirements, prior authorization requirements, or plan benefits, limitations or exclusions.

This *contract* provides "open access" coverage. "Open access" coverage means that *you* may elect to receive *your health care services* from any *participating provider* in a *provider* network. The *provider* network includes *specialists*. The *provider* directory or designated website will assist *you* in finding *participating providers*. *You* may schedule appointments with such *participating providers*, including OB/GYNs, without any referral. However, it is important that *you* verify that the *provider* still participates with the *provider* network before *you* actually receive any *health care services*. If *you* have questions about the status of *participating providers*, *you* may call the Customer Service number listed on *your* ID card for assistance.

E. Medical *Emergency*

You should be prepared for the possibility of a medical *emergency* by knowing *your participating provider's* procedures for "on call" and after regular office hours before the need arises. Determine the telephone number to call, which *hospital your participating provider* uses, and other information that will help *you* act quickly and correctly. Keep this information in an accessible location in case a medical *emergency* arises.

If the situation is a medical *emergency* and if traveling to a *participating provider* would delay *emergency* care and thus endanger *your* health, *you* should go to the nearest medical facility. However, call the phone number shown on *your* id card or *your participating provider* within 48 hours or as soon as reasonably possible to discuss *your* medical condition and to coordinate any follow-up care. *You* may authorize someone else to act on *your* behalf.

F. The Entire *Contract*

This *contract,* combined with any amendments (and *your* completed application), and any other documents referenced in this *contract,* excluding the Summary of Benefits and Coverage, constitute the entire *contract* between *you* and *us.* No change in this *contract* will be valid until approved by one of *our* executive officers and unless such approval is endorsed hereon or attached hereto. No agent has the authority to change this *contract* or to waive any of its provisions. *We* have the right to rely upon the information provided as part of *your* enrollment.

G. 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 *contract*; (2) reduce, limit or deny payment of benefits under this *contract*; or (3) defend a claim under this *contract*; unless such statement is in writing, a copy of which is supplied to the *subscriber*.

We will not contest the validity of *your* coverage under this *contract* after *your* coverage has been in force for two years except for: (1) nonpayment of premium; or (2) a fraudulent statement contained in a document signed by that person or in an application or supplemental application, if any, for that person, a copy of which is supplied to the *subscriber.*

H. Summary of Benefits and Coverage (SBC)

The SBC is an informational summary of *your* benefits and coverage under this *contract,* including coverage examples, that is prepared in a uniform style. If there is a conflict between this *contract* and the SBC, this *contract* governs and *we* will administer *your* coverage in accordance with this *contract. You* can obtain the SBC by contacting Customer Service or accessing the designated website.

I. *Your* Identification Card

We will issue *you* an identification (ID) card containing coverage information. Please verify the information on the ID card and notify Customer Service if there are errors. If any ID card information is incorrect, claims or bills for *your* health care may be delayed or temporarily denied. *You* will be asked to present *your* ID card whenever *you* receive services.

J. *Provider* Directory

You may find *participating providers* on *our* website at https://p1.aspirushealthplan.com/find-a-doctor. Coverage may vary according to *your provider* selection.

The list of *participating providers* frequently changes, and *we* do not guarantee that a listed *provider* is a *participating provider*. *You* should verify that a *provider you* choose is a *participating provider* by calling Customer Service. *Provider* directories are available to *you* upon request.

K. *Premium* Payment

Your premium payments are due monthly and, other than the first month, must be paid within a certain number of days after the *premium* due date. That number of days is known as the grace period, described further below. *We* have the right to change the *premium* due date and *premium* rates like *yours* and will notify *you* in advance of any changes. *Your premium* is the same as other *subscribers* of like age and number of *dependents* who are covered under contracts like *yours*. We will notify *you* of the new *premium* on *your* billing statement if *your premium* changes.

This *contract* will continue in force as long as *premium* payments are made before the due date or within the grace period described below. *We* have the right to terminate this *contract* due to non-payment of *premium*, rescind this *contract* due to fraud or intentional misrepresentation of a material fact, or to cancel this *contract* as otherwise described in the Ending *Your* Coverage provision of this *contract*. This *contract* will not be renewed if *we* cease doing individual market business in Wisconsin or as specified herein. Payment of a claim does not preclude *us* from denying future claims or taking any legal action *we* determine is appropriate, including *rescission* and seeking repayment of claims already paid.

***Premium* Payment from Third Parties:** *We* do not accept *premium* payments from third parties including, but not limited to, employers of *members*, *subscribers* or *dependents*, except when (a) acceptance of payment from a third party is specifically required by applicable federal or state law, (b) payment of the entire monthly *premium* is made from or on behalf of an individual coverage health reimbursement account (ICHRA) by the sponsoring employer, administrator or third party administrator of such ICHRA, (c) payment of the entire monthly *premium* is made from or on behalf of qualified small employer health reimbursement arrangement (QSEHRA) by the sponsoring employer, administrator, or third party administrator of such QSEHRA, or (d) payment is made by an affiliate of *us*. *We* may deny acceptance of, or stop accepting, *premium* payments from third parties only as permitted by applicable federal or state law.

L. Grace Periods

After *your* first payment of *premium*, *we* allow a 10-calendar day grace period for *premium* payment. The grace period starts on the day after the due date for payment. *You* are covered during this grace period provided payment of *premium* is made by the end of the grace period. If *we* do not receive payment by the end of the grace period, this *contract* is cancelled retroactively to the last date for which coverage has been paid in full.

If *your* coverage is terminated for nonpayment, *you* may not be able to obtain new coverage until the next annual open enrollment period, unless *you* experience a qualifying event that provides *you* or *your dependents* a right to a limited open enrollment period under this *contract*. The section entitled "Eligibility, Enrollment and *Effective Date*" in this *contract* explains annual open enrollment and limited open enrollment periods.

M. Reinstatement (after *contract* termination for nonpayment of premium)

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

To have *your* coverage reinstated, *you* must send to *us* a premium payment for all previously missed months plus payment for the next month. *You* must send this payment within 60 days of the date *your contract* was terminated. If *we* accept *your* payment, *your* coverage will be reinstated as of the date *your contract* was terminated. *We* will notify *you* within 45 days of receiving *your* payment if *we* accept. If reinstated, *your* coverage will continue as if it had never been terminated.

We will only allow *you* to reinstate this *contract* one time per *calendar year*. *You* cannot reinstate *your contract* if *you* purchased it through the *Health Insurance Marketplace*.

N. Changes in Coverage

We may discontinue offering all health insurance in the individual market. If that happens, *we* will provide *you* with written notice that coverage is being discontinued, as required by law.

The coverage provided under this *contract* and the *premiums* due for that coverage may change each year. Such changes may include changes in order to meet federal regulatory requirements, or state regulatory requirements to the extent that such requirements are not preempted by federal regulatory requirements, or to ensure that this *contract* maintains the actuarial value for the designated metal levels as defined in the *Affordable Care Act.* Any change in coverage required by statute or regulation becomes effective according to statute or regulation.

We may also modify or non-renew this *contract* on a uniform basis among all individuals with the same coverage as long as such change is in compliance with applicable federal law, or state law to the extent that such law is not preempted by federal law. *We* may also non-renew this *contract* if the *subscriber* moves outside the *geographical service area* for this *contract.* This *contract* is guaranteed renewable at a premium rate that does not take into account *your* claims experience or *your* health status.

If coverage is modified, *we* will provide *you* written notice of the change, as required by law.

O. Conflict with Existing Law

If any provision of this *contract* conflicts with any applicable statute or regulation, only that specific provision is hereby amended to conform to the minimum requirements of such statute or regulation.

P. Privacy

We are subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule. In accordance with the HIPAA Privacy Rule, *we* maintain, use, or disclose *your* Protected Health Information for purposes such as claims processing, utilization review, quality assessment, case management, and otherwise as necessary to administer *your* health care coverage. *You* will receive a copy of *our* Notice of Privacy Practices (which summarizes *our* HIPAA Privacy Rule obligations, *your* HIPAA Privacy Rule rights, and how *we* may use or disclose health information protected by the HIPAA Privacy Rule) with *your* enrollment packet. *You* may also call Customer Service to receive one.

Q. Fraud or Intentional Misrepresentation and *Rescission*

If routine processing delays or clerical errors occur, those delays will not deprive *you* of coverage for which *you* are otherwise eligible, nor will they give *you* coverage under this *contract* for which *you* are not eligible under this *contract*. *You* will not be eligible for coverage beyond the scheduled termination of this *contract* because of a failure to record or communicate the termination except where required by law. *Your* coverage may not be rescinded unless *you* (or anyone seeking coverage on *your* behalf, including a personal representative) falsify, or intentionally misrepresent or omit, information on *your* enrollment application form, submit fraudulent, altered or duplicate billings for *your* or others' personal gain, allow another person not covered under this *contract* to use *your* coverage, or perform an act or practice that constitutes fraud or intentional misrepresentation (including an omission) of material fact under the terms of this *contract*. *We* will provide *you* with a minimum of 30 calendar days advance written notice of the pending *rescission*. Notwithstanding this, *your* coverage may be terminated, including being retroactively terminated, due to *your* failure to timely pay *your* required *premiums*.

R. Authorizations and Right to Audit

Determination of *your* coverage will be made at the time a claim is reviewed. In addition, *we* or *our* designee may require *you* to furnish proof of *your* eligibility status, including eligibility for limited open enrollment, and may, at reasonable times and upon reasonable notice, audit or have audited *your* records regarding eligibility, enrollment, termination, *premium* payments and the coverage provided under this *contract*. If *we* determine that, after reasonable requests, *you* have failed to provide adequate records or authorizations for the release of information, or sufficient proof, *we* may, in *our* sole discretion, deny claims, cancel or not renew *your* coverage or rescind or terminate *your* coverage to the extent permitted by law.

S. Assignment

We will have the right to assign any and all of *our* rights and responsibilities under this *contract* to any of *our* affiliates or to any other appropriate organization or entity.

T. Medical Equipment, Supplies and *Prescription Drugs*

Your coverage under this *contract* does not guarantee that coverage of medical equipment, supplies or *prescription drugs* will continue to be covered, even if the equipment, supply or drug was covered in a previous *calendar year*.

U. Medical Technology and Treatment Review

Depending on the focus of the technology or treatment, one of two committees (Medical Policy Quality Management Subcommittee or the Pharmacy and Therapeutics Quality Management Subcommittee) determines whether new and existing medical treatments and technology should be covered benefits. These committees are made up of *our* designee's staff and independent community *physicians* who represent a variety of medical specialties. Their goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. These committees carefully examine the scientific evidence and outcomes for each treatment/technology being considered. The Quality Management Committee that is made up of independent community *physicians*, a consumer representative, and *our* and *our* designee's staff oversees the decisions of the subcommittees.

V. Recommendations by Health Care *Providers*

In some cases, *your provider* may recommend or provide written authorization for services that are specifically excluded by this *contract*. When these services are referred or recommended, a written authorization from *your provider* does not override any specific *contract* exclusions.

W. Legal Actions

No legal action may be brought until at least 60 calendar days after written proof of loss is provided or after the expiration of three years after the date that written proof of loss was provided.

X. *Routine Patient Costs* Associated with *Clinical Trials*

We cover *routine patient costs* associated with a *clinical trial* and may not: 1) deny *your* participation in a *clinical trial*; 2) deny (or limit or impose additional conditions on) the coverage of *routine patient costs* for items and services furnished to *you* in connection with participation in the *clinical trial*; or 3) discriminate against *you* on the basis of *your* participation in a *clinical trial.*

If one or more *participating providers* are participating in a *clinical trial*, *we* will cover *routine patient costs* only if *you* participate in the *clinical trial* through a *participating provider* if the *provider* will accept *you* as a participant in the *clinical trial.* This requirement is waived if the approved *clinical trial* is conducted outside the state in which *you* reside. *We* will not cover *routine patient costs* if *you* are participating in a *clinical trial* with a *non-participating provider* and *you* do not have coverage for *non-participating provider benefits*. *We* will also cover reasonable and *medically necessary health care services* for diagnosis and treatment of complication arising from participation in a qualifying *clinical trial*.

VI. Eligibility, Enrollment, and *Effective Date*

Eligible Individuals. An individual is eligible for coverage as a *subscriber* under this *contract* if, at the time of application, the *subscriber* is a resident in the *geographical service area* for which this *contract* is issued and has been determined by *us* to be an *eligible individual.*

Note: Coverage will be rescinded or terminated in the event of fraud, intentional misrepresentation of material fact (including a misleading omission of material fact) or failure to pay, when due, any required *premium.*

Eligible *Dependents*. A *subscriber* is permitted to enroll only eligible *dependents.* Eligible *dependents* of the *subscriber* include those individuals whom *we* have determined to be *eligible individuals* and who meet the requirements of any of the following:

1. Lawful spouse whose marriage to the *subscriber* is valid under Wisconsin law.
2. Children, through end of the month in which the child reaches age 26, including:
    a. Natural children of a covered *subscriber* from birth.
    b. Legally adopted children or children placed with the *subscriber* for legal adoption (date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support).
    c. Children under age 26 for whom the *subscriber* or the *subscriber's* covered lawful spouse has been appointed legal guardian by a court of law prior to age 18
    d. *Stepchildren* of the *subscriber*.
    e. Biological child of a *subscriber's* child (i.e. the *subscriber's* grandchild) if the *subscriber's* child is under age 18.
3. Child of the *subscriber* who is a *full-time student returning from military duty*.
4. Dependent children who are disabled. Application for extended coverage and proof of incapacity must be furnished to *us* within 31 calendar days after the dependent child reaches age 26. *We* may ask for an independent medical exam to determine the functional capacity of the dependent child. After this initial proof, *we* may request proof again annually. A dependent child may be eligible for coverage if coverage has not otherwise terminated by *us* and if the dependent child meets all of the following criteria:
    a. Became disabled before age 26;
    b. Was covered under this *contract* before age 26;
    c. Was a *dependent* enrolled under this *contract* prior to reaching age 26;
    d. Is incapable of self-sustaining employment, because of a *physical disability*, developmental disability, mental illness, or mental health disorder; and
    e. Is dependent on the *subscriber* for a majority of support and maintenance.

    The disabled dependent child shall be eligible for coverage as long as the dependent child is and continues to be disabled and dependent on the *subscriber*, unless coverage otherwise terminates under this *contract.*

Note: Coverage will be rescinded or terminated in the event of fraud, intentional misrepresentation of material fact (including a misleading omission of material fact) or failure to pay, when due, any required *premium.*

Initial Enrollment and Subsequent Enrollment. The *subscriber* must make written application to enroll, including any eligible *dependents* that the *subscriber* wishes to enroll, during an open enrollment period which occurs from November 1 through December 15 of each year. The *subscriber* may add eligible *dependents* to this *contract* at subsequent annual open enrollment periods. They may also be enrolled in connection with a limited open enrollment period as described in the "Limited Open Enrollment," Section below. For further information regarding open enrollment, please contact Customer Service. If *you* have subscriber only coverage and elect coverage for *your* eligible *dependents* which becomes effective, then *you* and *your dependents* become subject to the terms and conditions of family coverage.

Newborn Child Enrollment Under Wisconsin Law. Newborn biological children who are born while the *subscriber* is covered under this *contract* and who are otherwise eligible for coverage, will be covered immediately from the moment of birth and for the next 60 days of the child's life immediately following the date of birth. If coverage is needed after the 60 days, *you* must add the child.

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

be retroactive to the date of birth. If *we* do not receive payments within one year after the child's birth, the newborn may not be added until the next annual enrollment period.

Newly Adopted Child Enrollment. Children newly adopted or placed for adoption, who were adopted or placed for adoption while the *subscriber* is covered under this *contract*, and who are otherwise eligible for coverage, may be covered immediately from the date of adoption or placement for adoption, or on a later date elected by the *subscriber*. *We* must receive an application to add the child within 60 days of the date of adoption or placement for adoption. If *you* submit an application more than 60 calendar days after the date of adoption, or placement for adoption, the adopted child may not be added until the next annual enrollment period.

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

***Effective Date* for Initial Enrollment.** The date on which coverage is effective for the *subscriber* and all enrolled *dependents* who are listed on the application depends on the date *you* are approved for coverage by *us* and *our* receipt of the full amount due for *your* first monthly *premium* payment. If the conditions are met on or before December 15 in any calendar year, *your* coverage will be effective January 1 of the following calendar year.

Limited Open Enrollment. If *your* circumstances change, *you*, *your* spouse, and *your dependents* may have a limited open enrollment right to enroll in this *contract* or another *health plan* or in a *qualified health plan*, as applicable. The events that may permit such limited open enrollment in this *contract* are generally described in the chart below; **however, they are subject to change as permitted or required by law, regulatory guidance or applicable market practices**. The chart contains the events that apply when *you* purchase coverage directly from *us* under this *contract*. If one of the listed events applies to *you*, *you* must elect coverage in a timely manner as required by law and must submit *your* completed application and required documentation to *us* to obtain coverage under this *contract*.

The timeframe for electing coverage varies with the type of event.

- For events 3, 4, 5, 9 and 10 in the chart below, coverage must be elected no later than 60 calendar days after the date the event occurs. For events involving a child support order or other court orders, the date the event occurs is the date the order is issued.
- For events 1, 2, and 14 in the chart below, coverage must be elected during the period that begins 60 days before and ends 60 days after the date the event occurs. The triggering event for event 14 is the first day on which coverage for the *eligible individual* or *dependent* under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect.[1]
- For events 6, 7, and 8 in the chart below, the coverage election periods vary with the circumstances, but generally cannot exceed 60 days.
- For event 11 in the chart below, coverage must be elected no later than 60 calendar days from the date of such event.
- Special rules apply to events 12 and 13. Contact Customer Service if *you* have questions about these special rules.

In addition to electing timely, for events 1, 2, 3 (for marriage), 4 (for marriage), 5, 7 and 8, an *eligible individual* must demonstrate either enrollment in *minimum essential coverage* for at least 1 day during the 60 day period prior to the date of the event or that the *eligible individual* lived in a foreign country or U.S. territory for 1 or more days during the 60 day period prior to the date of the event or lived in a service area where no *qualified health plans* were available through the *Health Insurance Marketplace* (i) for 1 or more days during the 60 day period prior to the date of the event or (ii) during their most recent preceding enrollment period (which includes initial, annual or a limited open enrollment period). In addition to electing timely, for event 11, an *eligible individual* must demonstrate that they are currently enrolled in *minimum essential coverage* at the time they seek to enroll in coverage that is separate from the perpetrator's coverage. For further information regarding these limited open enrollment rules, please contact Customer Service.

Note: If *you* are an *eligible individual* or a *qualified individual*, as applicable, or a spouse or an eligible dependent child of an *eligible individual* or a *qualified individual*, as applicable, but are not enrolled for coverage under this *contract*, *you* may also enroll for coverage under this *contract*, as provided by the *Affordable Care Act*, as a result of qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. For further information regarding these limited open enrollment rules, please contact Customer Service.

[1] An *eligible individual* or *dependent* will qualify for this special enrollment period regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the *eligible individual* or *dependent* is not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to the triggering event.

***Effective Date* of Coverage Pursuant to Limited Open Enrollment.** The *effective date* of coverage for the *subscriber* and/or any eligible *dependents* listed on the enrollment form depends on the date on which *we* timely receive *your* coverage selection and approve it, and *we* receive the full amount of the first monthly *premium* payment.

- If the event is the birth, adoption, placement for adoption or child support or other court order in relation to an eligible dependent child as set forth in events 3 or 4 in the chart below, coverage is effective on the date of the birth, adoption, placement for adoption or effective date of the court order; unless the *subscriber* elects that the coverage be effective on the first day of the month following plan selection or unless the *subscriber* elects the regular coverage *effective dates*; provided that all conditions described in this section are met. For regular coverage *effective dates*, if plan selection is received on or after the first day of the month, but on or before the fifteenth day of the month, *your* regular coverage *effective date* will be the first day of the following month and if plan selection is received after the sixteenth day of the month, but on or before the last day of the month, *your* regular coverage *effective date* will be the first day of the second following month.
- If the event is marriage as set forth in events 3 or 4 in the chart below, coverage is effective on the first day of the month following the date the *subscriber* timely elects coverage, provided that all conditions described in this section are met.
- For a loss of coverage for event 5 in the chart below, coverage is effective on the first day of the month following the date the *subscriber* timely elects coverage, provided that all conditions described in this section are met.
- If the event is the loss of *minimum essential coverage* or the loss of coverage due to non-renewal (including voluntary non-renewal) or expiration of coverage under a non-calendar year group or individual *health plan* or an employer-sponsored plan that provides minimum value in accordance with the *Affordable Care Act* and as set forth in events 1 or 2 in the chart below, coverage is effective on the first day of the month following the date of the loss of coverage, provided that the *subscriber* timely elects coverage on or before the date of such loss and provided that all conditions described in this section are met. If *subscriber* timely elects coverage after the date of such loss of coverage, coverage is effective on the first day of the month following plan selection. For a loss of coverage due to such non-renewal or expiration of coverage, the date of the loss of coverage is the last day of the non-calendar plan year that immediately precedes the renewal date or the last day of the non-calendar plan year in which coverage expired, respectively. Special rules apply if coverage is elected after the loss of coverage occurs.
- If the event is a permanent move as set forth in event 8 in the chart below, if all conditions described in this section are met on or after the first day of the month, but on or before the fifteenth day of the month, *your* coverage under the events listed below will be effective on the first day of the following month. If the conditions are met on or after the sixteenth day of the month, but on or before the last day of the month, *your* coverage will be effective on the first day of the second following month. Special rules apply if coverage is elected before the permanent move occurs.
- For events 9,10 and 11 in the chart below, if all conditions described in this section are met on or after the first day of the month, but on or before the fifteenth day of the month, *your* coverage under the events listed below will be effective on the first day of the following month. If the conditions are met on or after the sixteenth day of the month, but on or before the last day of the month, *your* coverage will be effective on the first day of the second following month.
- The coverage effective dates for events 6, 7, 12, 13 and 14 vary with the circumstances and special rules apply.

For further information regarding these limited open enrollment election period rules, please contact Customer Service.

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
1. An *eligible individual* experiences: ▪ An involuntary loss of *minimum essential coverage*[2], or ▪ A loss of coverage due to non-renewal (including voluntary non-renewal) or expiration of coverage under a non-calendar year group or individual *health plan,* qualified small employer health reimbursement arrangement or a non-calendar year employer-sponsored plan that provides minimum value in accordance with the *Affordable Care Act*. The date of the loss of this type of coverage is the last day of the non-calendar year plan or policy year. ▪ A loss of pregnancy-related coverage under Medicaid or state CHIP or a loss of access to health care services through coverage provided to the pregnant woman's unborn child through Medicaid or state CHIP.	▪ The *subscriber* ▪ Individuals who are the *subscriber's* spouse and/or eligible dependent children.	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan.*

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
2. An *eligible individual's* spouse and/or eligible dependent children experience: ▪ An involuntary loss of other *minimum essential coverage*[2], or ▪ A loss of coverage due to non-renewal (including voluntary non-renewal) or expiration of coverage under a non-calendar year group or individual *health plan,* qualified small employer health reimbursement arrangement or a non-calendar year employer-sponsored plan that provides minimum value in accordance with the *Affordable Care Act.* The date of the loss of this type of coverage is the last day of the non-calendar year plan or policy year. ▪ A loss of pregnancy-related coverage under Medicaid or state CHIP or a loss of access to health care services through coverage provided to the pregnant woman's unborn child through Medicaid or state CHIP.	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
3. A *subscriber* newly gains a spouse or becomes a spouse or newly gains an eligible dependent child through marriage, birth, adoption, placement for adoption, child support order or other court order. **Note:** For marriage, at least one spouse must be able to demonstrate that they had *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days prior to the marriage effective date.	▪ The *subscriber* ▪ Individuals who are the *subscriber's* spouse and/or newly acquired eligible dependent children of the *subscriber* or of the new spouse	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
4. An *eligible individual* newly gains a spouse or becomes a spouse or newly gains an eligible dependent child through marriage, birth, adoption, placement for adoption, child support order or other court order.	▪ The *eligible individual* ▪ Individuals who are the *subscriber's* spouse and/or newly acquired eligible dependent children of the *subscriber* or of the new spouse	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
5. An *eligible individual* or *dependent* who is enrolled in a *qualified health plan* and loses coverage as a result of: ▪ a loss of dependent status because they are no longer considered a *dependent*, or ▪ through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or ▪ the death of the *eligible individual* or *dependent* who is enrolled in a *qualified health plan.*	▪ The *eligible individual.* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual.*	▪ Enroll in this *contract.* ▪ Change *your* enrollment to another *health plan.*

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
6. The *Health Insurance Marketplace* determined that an *eligible individual* or *dependents* whose enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous, as a result of an error, misrepresentation, misconduct or inaction by the *Health Insurance Marketplace*, the U.S. Department of Health and Human Services, its instrumentalities, or a non-exchange entity that provided *Health Insurance Marketplace* enrollment assistance or conducted *Health Insurance Marketplace* enrollment activities with *you*, as determined by the *Health Insurance Marketplace* in accordance with guidelines and standards established by the *Health Insurance Marketplace*. **Note:** For purposes of this event, a non-exchange entity is defined as an agent, broker, certified application counselor, navigator, issuer application assister, *qualified health plan* participating in the *Health Insurance Marketplace* and non-Navigator assistance personnel that assist consumers in enrolling in a *qualified health plan* through the *Health Insurance Marketplace*.	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
7. An *eligible individual* or *dependent* who is enrolled in a *qualified health plan* adequately demonstrates to the applicable state authority within the meaning of federal law and in accordance with guidelines and standards established by such authority, that such *qualified health plan* substantially violated a material provision of its contract in relation to such *qualified individual* or *dependent.*	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
8. An *eligible individual* or *dependent* permanently moves into *our geographical service area* or into a new service area in Wisconsin, which causes such individual to gain access to a new *qualified health plan.* **Note:** Must demonstrate that *eligible individual* or *dependent* had *minimum essential coverage* as described in 26 CFR 1.500A-1(b) for one or more days during the 60 days prior to the effective date of the permanent move.	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
9. The *Health Insurance Marketplace* determines that an *eligible individual* who is enrolled in a *qualified health plan* is newly ineligible for the advance payment of premium tax credits or cost-sharing reductions as defined by the *Affordable Care Act*.	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
10. The *Health Insurance Marketplace* determines that an *eligible individual*'s dependent who is enrolled in the same *qualified health plan* as the *eligible individual* is newly ineligible for the advance payment of premium tax credits or cost-sharing reductions as defined by the *Affordable Care Act.*	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
11. An *eligible individual* who: ▪ Is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B-2 or a *dependent* and unmarried victim within a household who is enrolled in *minimum essential coverage* and seeks to enroll in coverage separate from the perpetrator of such abuse or abandonment, or ▪ Is a *dependent* of a victim of domestic abuse or spousal abandonment on the same application as the victim.	▪ The *eligible individual* who is the victim of such abuse or abandonment ▪ Individuals who are eligible *dependents* of the victim	▪ Enroll in this *contract* ▪ Any eligible *dependents* must enroll in this contract at the same time and on the same application as the victim ▪ End *your* coverage under this *contract* in order to enroll in other coverage that is separate from the perpetrator of such abuse or abandonment

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
12. An *eligible individual* or dependent who applies for coverage through the *Health Insurance Marketplace* during open enrollment or due to a qualifying event, is determined potentially eligible for Medicaid or CHIP, but is determined ineligible after open enrollment ends or more than 60 days after the qualifying event	▪ The *eligible individual* ▪ Other *eligible individual*s who are the spouse and/or eligible *dependent* children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
13. An *eligible individual* or dependent who applies for state Medicaid or CHIP during open enrollment, but is determined ineligible after open enrollment ended	▪ The *eligible individual* ▪ Other *eligible individual*s who are the spouse and/or eligible *dependent* children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
14. An *eligible individual* or dependent newly gains access to an individual coverage health reimbursement arrangement (HRA) (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code).	▪ The *eligible individual* ▪ Other *eligible individual*s who are the spouse and/or eligible *dependent* children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan* that meets the *minimum essential coverage* requirements

[2]For purposes of this *contract*, an involuntary loss of *minimum essential coverage* includes, but is not limited to, the following examples:

- Termination of health coverage, that is not COBRA or state continuation coverage, due to a loss of eligibility for such coverage (including as a result of legal separation or divorce from primary insured subscriber, death of primary insured subscriber, termination of employment (including voluntarily leaving employment) or reduction in hours by the primary insured subscriber under an individual or group plan, cessation of dependent status (including but not limited to attaining age 26), and a loss of coverage provided through an HMO in the group or individual market or other arrangement due to the individual no longer residing or working in the service area designated by the HMO or other arrangement);
- Termination of all employer contributions toward the cost of such health coverage (excluding COBRA);
- Expiration of COBRA and any state continuation health coverage due to exhaustion of such coverage;
- Loss of eligibility for Medicaid;
- Loss of eligibility for CHIP; and
- An employer-sponsored health plan discontinues offering any health benefits to similarly situated individuals.

Loss of *minimum essential coverage* does not include, and is not limited to, the following examples:

- Voluntary loss of *minimum essential coverage*;
- Loss of non-*minimum essential coverage* unless an exception applies;
- Loss of *minimum essential coverage* due to a failure to pay *premiums* on a timely basis including COBRA *premiums* while on COBRA continuation coverage; and
- Loss of coverage due to a *rescission* of coverage (as permitted under the *Affordable Care Act*) by *us*, another carrier, a regulatory or government agency or an employer due to fraud or an intentional misrepresentation of material fact.

VII. Schedule of Payments

You **are required to pay any** ***copayments, deductibles*** **and** ***coinsurance*** **amounts. Benefits are covered in this** ***contract*** **according to what** ***we*** **pay for** ***covered services*** **that** ***we*** **determine are** ***medically necessary. Medically necessary*** **is defined in the Definitions section of this** ***contract. Your coinsurance*** **amount is the** ***eligible charge*** **for a** ***covered service*** **less the percentage covered by** ***us. Our*** **payment begins after** ***you*** **have satisfied any applicable** ***copayments, deductibles*** **and** ***coinsurance.***

Discounts negotiated by or on behalf of ***us*** **with** ***providers*** **may affect** ***your coinsurance*** **amount.** ***We*** **may pay higher benefits if** ***you*** **choose** ***participating providers.*** **In addition to any** ***copayments, coinsurance*** **and** ***deductible, you*** **also pay all charges that exceed the** ***non-participating provider reimbursement value*** **when** ***you*** **use a** ***non-participating provider*** **and receive** ***non-participating provider benefits.***

Note: *Your* coverage is either "*subscriber* only" or "family." Therefore, only one of the following sections "*Subscriber* only" or "Family" applies to *you*. If *you* have questions about which section applies to *you*, contact Customer Service.

If *you* have *subscriber* only coverage, on the date that the coverage for *your* eligible *dependent(s)* becomes effective, *you* and *your* new *dependent(s)* become subject to the terms and conditions of family coverage.

Subscriber only

Deductibles**:** The *subscriber* must first satisfy the *deductibles* by *incurring* charges equal to that amount for eligible services in a *calendar year* before *we* will pay benefits. *We* will not pay benefits for the *eligible charges* applied toward the *deductibles.* Expenses *you* pay for *copayments, coinsurance* and any amount in excess of the *non-participating provider reimbursement value* will not apply towards satisfaction of the *deductibles*. *You* will not be required to satisfy the *deductibles* before *we* will pay benefits for *preventive health care services* received from a *participating provider.*

Out-of-Pocket Limits**:** After the *subscriber* has met the *out-of-pocket limit* per *calendar year* for *copayments, coinsurance* and *deductibles*, *we* cover 100% of charges *incurred* for all other *eligible charges*. It is the *subscriber's* responsibility to pay any amounts greater than the *out-of-pocket limit* if any benefit or visit maximums are exceeded. Expenses *you* pay for amounts in excess of the *non-participating provider reimbursement value* will not apply towards satisfaction of the *out-of-pocket limit.*

Subscriber **only**	***Participating Provider Network***	***Non-Participating Providers***
Deductibles	None.	Not applicable.
Out-of-Pocket Limits	$650 per *calendar year.*	Not applicable.

Family (*Subscriber* and Enrolled *Dependents*)

Family *Deductibles*: If *you* have family coverage, each covered family *member* must meet their own individual *deductible* until the total amount of *deductible* expenses paid by all family *members* meets the overall family *deductible*. *We* will not pay benefits for the *eligible charges* applied toward the family *deductibles*. Expenses the family pays for *copayments, coinsurance* and any amount in excess of the *non-participating provider reimbursement value* will not apply towards satisfaction of the *deductibles*. *Members* of the family will not be required to satisfy the family *deductibles* before *we* will pay benefits for *preventive health care services* received from a *participating provider*.

Family *Out-of-Pocket Limits*: If *you* have family coverage, each family *member* must meet their own individual *out-of-pocket limit* until the overall family *out-of-pocket limit* has been met. The family must pay any amounts greater than the family *out-of-pocket limit* if any benefit or visit maximums are exceeded. Expenses the family pays for amounts in excess of the *non-participating provider reimbursement value* will not apply towards satisfaction of the *out-of-pocket limit.*

Family (*Subscriber* and *Dependents*)	***Participating Provider Network***	***Non-Participating Providers***
Family *Deductibles*	None.	Not applicable.
Family *Out-of-Pocket Limits*	$1,300 per family ($650 per *member*) per *calendar year*.	Not applicable.

Cost Sharing. The amount of the flat fee *copayments* is calculated on *provider* allowed charges. The *provider's* allowed charge is the full amount that the *provider* bills less any discount negotiated by or on behalf of *us* with the *provider*. The *coinsurance* percentage is calculated on the least of the *provider's* allowed charge, the *fee schedule* that *we* have negotiated with the *participating provider*, or the *non-participating provider reimbursement value.*

VIII. Prior Authorization

Approval of a prior authorization request by *us* or *our* designee does not guarantee payment for services. Whether or not *we* grant prior authorization, payment for services will depend on whether, at the time the services are performed, *you* are a *member* who is *eligible* for and enrolled under this *contract,* the services are *medically necessary*, are *covered services, you have* provided the appropriate information for those services, and *you* have met all other terms of the *contract*. Please read the entire *contract* to determine which other provisions might also affect benefits.

If *your* attending *provider* requests prior authorization on *your* behalf, the attending *provider* will be treated as *your* authorized representative by *us* for purposes of such request and the submission of *your* claim and associated appeals unless *you* specifically direct otherwise to *us* within ten business days from *our* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

Prior Authorization Recommendation. *We* recommend that *you* or *your provider* request prior authorization for certain *health care services* to determine whether they are *medically necessary*. When a *participating provider* renders services, the *provider* will obtain authorization in advance from *us* or *our* designee for *you* by following the procedures explained in this section of this *contract*. It is *your* responsibility to obtain prior authorization from *us* and to follow the procedures in this section of this *contract* when *you* receive services from *non-participating providers*. If *you* have questions about prior authorization, please contact Customer Service. Penalties do not apply. *You* and *your provider* should follow the procedures for prior authorization appeals as shown in the "Internal Appeals Process" section. The prior authorization process is recommended for a variety of services including, but not limited to, those listed below, and others that are listed in *our* "Prior Authorization List":

1. All non-*emergency* inpatient admissions including *skilled nursing facility*, rehabilitation, *hospital*, etc.;
2. *Transplant services*;
3. Drugs or procedures that could be construed to be *cosmetic*;
4. Home health care or hospice;
5. Non-*emergency* transportation
6. Outpatient surgeries;
7. Physical therapy, occupational therapy, speech therapy and other outpatient therapies;
8. Pain therapy;
9. *Reconstructive* surgery; and
10. Durable medical equipment (DME) or prosthesis that might exceed $5,000.

You can access the current list by logging in to *your member* home page at www.aspirushealthplan.com.

We also recommend that *you* or *your provider* request prior authorization for certain *prescription drugs* before *you* fill *your* prescription at a pharmacy. These *prescription drugs* include, but are not limited to:

1. *Compounded drugs* that are over $200.
2. *Specialty drugs.*

Prior Authorization Procedure for Non-Acute Care Pre-Service Requests. When a *participating provider* renders services, the *participating provider* will notify *us* for *you* and must follow the procedures set forth below. It is *your* responsibility to ensure that *we* have been notified when *non-participating providers* are used. *You* or the *provider* must contact Customer Service by telephone, facsimile, electronic mail, or voice mail prior to services being performed and without unreasonable delay.

For *non-participating providers*, *you* need to follow the procedures set forth below:

1. *You* must contact Customer Service by telephone, facsimile, electronic mail, or voice mail prior to services being performed and no less than 15 calendar days prior to the date services are scheduled. An expedited review is available if *your attending health care professional* believes it is warranted.
2. *You* and the *provider* will be notified of the initial determination by *us* or *our* designee within ten business days following a request, but in no event later than the date on which the services are scheduled to be rendered, provided that *we* have all necessary information *we* need to make an initial determination. If *we* have all information *we* need to make an initial determination, but determine that an extension is necessary due to matters beyond *our* control, , then *we* may extend the

time period for *our* initial determination by sending written notice to *you* before the end of the initial determination period, which describes the circumstances that require the extension. *We* or *our* designee will notify *you* and the *provider* of the initial determination within ten business days after the end of the initial determination period. The initial determination will be communicated to the *provider* by telephone.

3. If *we* do not have all necessary information *we* need to make an initial determination, then *we* may extend the time period for making the initial determination by sending written notice to *you*, before the end of the initial determination period, which describes the missing information and provides a grace period to *you* for providing the necessary information of at least 45 calendar days from the date *you* receive the notice. *We* will notify *you* and the *provider* of the initial determination within ten business days after the earlier of a) the date on which *we* receive the requested information and b) the end of the specified grace period, if *we* do not receive the requested information. The initial determination will be communicated to the *provider* by telephone.
4. If the initial determination is that the service will not be covered *your attending health care professional*, *hospital* (if applicable) and attending *provider* will be promptly notified by telephone within one business day after the decision has been made.
5. Written notification will then be provided to *you*, *your attending health care professional, hospital* (if applicable) and attending *provider* explaining the principal reason or reasons for the determination. The notification will also include the process to appeal the decision.
6. If *you* or the *provider* has not submitted the request for review in accordance with these procedures, *we* will notify *you* within five calendar days.

Note: If *your* request is denied, *you* may appeal that decision. Refer to the section entitled "Internal Appeals Process" for details on how to appeal.

Should Wisconsin, Minnesota, the Wausau metropolitan area and/or the Minneapolis/St. Paul metropolitan area be declared subject to a pandemic alert or in the event of a cyber-attack, *we* may suspend prior authorization and other services as may be determined by *us.*

How to Obtain an Expedited Review

Expedited Review. An expedited initial determination will be used if *your attending health care professional* believes it is warranted. Acute care services, which can warrant expedited review, are medical care or treatment with respect to which the application of the time periods for making non-expedited review determinations could seriously jeopardize *your* life or health or *your* ability to regain maximum function, or that in the opinion of *your attending health care professional* would subject *you* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *pre-service* request.

An expedited initial determination will be provided to *you, your attending health care professional, hospital* (if applicable) and attending *provider* as quickly as *your* medical condition requires, but no later than 72 hours following the initial request. If *we*, or *our* designee, do not have all the information needed to make a determination, *you* will be notified within 24 hours. *You* will then have at least 48 hours to provide the requested information. *You*, *your attending health care professional*, *hospital* (if applicable) and attending *provider* will be notified of the determination within 48 hours after the earlier of *our* receipt of the requested information or the end of the time period specified for *you* to provide the requested information. If the initial determination would deny coverage, *you* or *your attending health care professional* will have the right to submit an expedited appeal

Note: If *your* request is denied, *you* may appeal that decision. Refer to the section entitled "Internal Appeals Process" for details on how to appeal.

Case Management

In cases where *your* condition is expected to be or is of a serious nature, *we* may arrange for review and/or case management services from a professional who understands both medical procedures and *our* health care coverage.

Under certain conditions, *we* will consider other care, services, supplies, reimbursement of expenses or payments for care of *your* serious *sickness* or *injury* that would not normally be covered. *We* and *your physician* will determine whether any medical care, services, supplies, reimbursement of expenses or payments will be covered. Such care, services, supplies, reimbursement of expenses or payments will not be considered as setting any precedent or creating any future liability.

Other care, treatments, services, or supplies must meet both of these tests:

1. Be determined in advance by *us* to be *medically necessary* and cost effective in meeting *your* long term or intensive care needs in connection with a catastrophic *sickness* or *injury*; and
2. The charges *incurred* would not otherwise be payable or would be payable at a lesser percentage.

Alternative Care

If *your attending health care professional* advises *you* to consider alternative care for a *sickness* or *injury* that includes *health care services* not covered under the *contract*, *your attending health care professional* should contact *us* so *we* can discuss it with them. *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 *contract*;

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 professional*, and *us* before such alternative care begins.

IX. Description of Benefits

1. **Also refer to the Schedule of Payments to help determine *your* benefit level.**
2. **See the Prior Authorization section for certain services.**
3. **Be sure to review the list of Exclusions. A *provider* recommendation or performance of a service, even if it is the only service available for *your* particular condition, does not mean it is a *covered service*. Benefits are not available for *medically necessary* services, unless such services are also *covered services,* and received while *you* are covered under this *contract*.**
4. **Benefits are limited to the most cost effective and *medically necessary* alternative.**

Benefit	***Participating Provider Benefit, we* pay*:***	***Non-Participating Provider Benefit, we* pay:** **Note:** For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *non-participating provider reimbursement value.*
A. Ambulance Services		
Ambulance services for an *emergency*.	70% of *eligible charges* after the *deductible.*	Same as the *participating provider* benefit for *emergency* ambulance services.
Non-*emergency* transportation. **Note:** Prior authorization by *us* or *our* designee. is recommended for non-*emergency* transportation	70% of *eligible charges* after the *deductible.*	Same as the *participating provider* benefit for non-*emergency* transportation.

Ambulance services for an *emergency*. *We* cover ambulance service and *emergency* transportation to the nearest *hospital* or medical center where initial care can be rendered for a medical *emergency*. Air ambulance is covered only when the condition is an acute medical *emergency* and is authorized by a *physician.* Prior authorization by *us* or *our* designee is recommended for non-*emergency* transportation.

We cover *emergency* ambulance (air or ground) transfer from a *hospital* not able to render the *medically necessary* care to the nearest *hospital* or medical center able to render the *medically necessary* care only when the condition is a critical medical situation and is ordered by a *physician* and coordinated with a receiving *physician.*

Ambulance services for a non-*emergency*. Non-*emergency* ambulance service, including transfers from *hospital* to *hospital* when care for *your* condition is not available at the *hospital* where *you* were first admitted, from a *hospital* to other facilities for subsequent covered care or from home to *physician* offices or other facilities for outpatient treatment procedures or tests, are covered if medical supervision is required en route. Prior authorization by *us* or *our* designee is recommended for non-*emergency* ambulance services in advance.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
B. Autism Services		
Services to diagnose and treat Autism.	70% of *eligible charges* after the *deductible.*	Not covered.

We cover autism services for *members* 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 professional* 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 *member*. Please see Wisconsin Administrative Code Ins. 3.36 for applicable definitions.

This section is not subject to the general exclusions in Section X entitled "Exclusion List". The only exclusions that apply to autism services are outlined in this section, except for *durable medical equipment* and *prescription drugs*.

Covered Autism Services:

1. **Diagnostic testing**. The testing tools used must be appropriate to the presenting characteristics and age of the *member* 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 *member* and *us.*
2. **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:
    a. Evidence-based.
    b. Provided by a qualified *provider*, professional, therapist, or paraprofessional, as those terms are defined by state law.
    c. Based on a treatment plan developed by a qualified *provider* or professional as defined by state law that includes an average of 20 or more hours per week over a six-month period of time with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that *you* be present and engaged in the intervention.
    d. Provided in an environment most conducive to achieving the goals of *you*r treatment plan.
    e. 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.
    f. Designed to include training and consultation, participation in team meetings and active involvement of the *member's* family and treatment team for implementation of the therapeutic goals developed by the team
3. **Concomitant services by a qualified therapist**. *We* will cover services by a qualified therapist when all the following are true:
    a. The services are provided concomitant with intensive-level evidence-based behavioral therapy;
    b. *You* have a primary diagnosis of an autism spectrum disorder;
    c. *You* are actively receiving behavioral services from a qualified intensive-level *provider* or qualified intensive-level professional; and
    d. The qualified therapist develops and implements a treatment plan consistent with their license and this section.
4. **Non-intensive-level services.** *You* are eligible for non-intensive-level services, including direct or consultative services, that are evidence-based and are provided by a qualified *provider*, supervising *provider*, professional, therapist or paraprofessional under one of the following scenarios: (i) after the completion of intensive-level services, as long as the non-intensive-level services are designed to sustain and maximize gains made during the intensive-level *treatment*; or (ii) if *you* have not and will not receive intensive-level services but non-intensive-level services will improve *your* condition. Non-intensive-level services must be all of the following:
    a. 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.

b. Implemented by qualified *providers*, qualified supervising *providers*, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law.
c. Provided in an environment most conducive to achieving the goals of *your* treatment plan.
d. Designed to provide training and consultation, participation in team meetings and active involvement of the *member's* family in order to implement therapeutic goals developed by the team.
e. Designed to provide supervision for qualified professionals and paraprofessionals in the treatment team.
f. 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.

Exclusions:

a. Acupuncture
b. Animal-based therapy including hippotherapy
c. Auditory integration training
d. Chelation therapy
e. Childcare fees
f. Cranial sacral therapy
g. Hyperbaric oxygen therapy
h. *Custodial care* or *respite care*
i. Special diets or supplements
j. *Provider* travel expenses
k. Therapy, treatment or services when provided to a *member* who is residing in a residential treatment center, inpatient treatment or day treatment facility
l. Costs for the facility or location or for the use of a facility or location when *treatment*, therapy or services are provided outside of *your* home
m. Claims that have been determined by us to be fraudulent
n. Treatment provided by parents or legal guardians who are otherwise qualified *providers*, supervising *providers*, therapists, professionals or paraprofessionals for treatment provided to their own children.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
C. Chiropractic Services		
Services to treat acute musculoskeletal conditions by manual manipulation therapy.	100% of *eligible charges* after a *copayment* of $35 per visit. *Deductible* does not apply.	Not covered.

NOTE: For coverage of other therapy services, please refer to the section entitled "Physical Therapy, Occupational Therapy and Speech Therapy"

Diagnostic services are limited to *medically necessary* radiology. Treatment is limited to conditions related to the spine or joints.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Routine *maintenance care.*
c. Blood, urine or hair analysis.
d. Performance of ultrasound, MRI, EMG, waveform and nuclear medicine diagnostic studies, or other enhanced imaging.
e. Manipulation under anesthesia.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
D. Dental Services		
Accidental Dental Services.	**Note**: Dental damage must be severe enough that initial contact with a *physician* or *dentist* occurred within 72 hours of the accident. *You* may request an extension of this time period provided that *you* do so within 60 days of the *injury* and if extenuating circumstances exist due to the severity of the *injury*. Treatment and repair must be completed within twelve months of the date of the *injury*.	
	70% of *eligible charges* after the *deductible.*	Not covered.
Medically Necessary Outpatient Dental Services and Hospitalization for Dental Care.	70% of *eligible charges* after the *deductible.*	Not covered.

This provision does not provide coverage for preventive dental procedures. *We* consider dental procedures to be services rendered by a *dentist* or *dental specialist* to treat the supporting soft tissue and bone structure.

We cover the following dental services**:**

1. **Accidental Dental Services**. *We* cover services to treat and restore damage done to sound, natural teeth as a result of an accidental *injury*. Coverage is for external trauma to the face and mouth only, not for cracked or broken teeth that result from biting or chewing. A sound, natural tooth is a tooth without pathology (including supporting structures) rendering it incapable of continued function for at least one year. Dental damage must be severe enough that initial contact with a *physician* or *dentist* occurred within 72 hours of the accident. *You* may request an extension of this time period provided that *you* do so within 60 days of the *injury* and if extenuating circumstances exist due to the severity of the *injury*. Treatment and repair must be completed within twelve months of the date of the *injury.*
2. ***Medically Necessary* Dental Services:** *We* cover dental services required for treatment of an underlying medical condition (e.g. removal of teeth to complete radiation treatment for cancer of the jaw, cysts, and lesions) and provided by a *dentist* or *dental specialist,* including general anesthesia, regardless of whether the services are provided in a *hospital* or a dental office.
3. ***Medically Necessary* Hospitalization for Dental Care:** *We* cover hospitalization for dental care. This is limited to charges *incurred* by a *member* who: (1) is a child under age 5; (2) is severely disabled; or (3) has a medical condition unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/*dentist* or *dental specialist* professional fees are not covered for dental services provided, except as described in item 2 above. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Care must be directed by a *physician* or by a *dentist* or *dental specialist.*

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Dental services covered under *your* dental plan.
c. Preventive dental procedures.
d. *Health care services* or dental services for and related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts.
e. Orthodontia and all associated expenses.
f. *Health care services* or dental services for or related to *oral surgery* and anesthesia for the removal of impacted teeth, removal of a tooth root without the removal of the whole tooth and root canal therapy.
g. *Health care services* or dental services for cracked or broken teeth that result from biting, chewing, disease or decay.
h. Dental implants, except due to *injury*.
i. Prescriptions written by a *dentist* unless in connection with dental procedures covered by *us.*
j. *Health care services* or dental services related to periodontal disease.
k. Occlusal adjustment or occlusal equilibration.
l. Treatment of bruxism.

m. Surgical extraction of impacted wisdom teeth, except as above for accidental injury to sound, natural teeth or when required for treatment of an underlying medical condition.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
E. Durable Medical Equipment ("DME") Services, Prosthetics, and Orthotics		
DME.	70% of *eligible charges* after the *deductible.*	Not covered.
Orthotics.	70% of *eligible charges* after the *deductible.*	Not covered.
Prosthetics.	70% of *eligible charges* after the *deductible.*	Not covered.
Insulin pump, limited to one pump per *calendar year*	70% of *eligible charges* after the *deductible.*	Not covered.
Diabetic supplies Coverage includes over-the-counter diabetic supplies, including glucose monitors, syringes, blood and urine test strips, and other diabetic supplies as *medically necessary.*	70% of *eligible charges* after the *deductible.*	Not covered.
Speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to *sickness* or *injury.*	70% of *eligible charges* after the *deductible.*	Not covered.

We cover equipment and services ordered by a *physician* and provided by DME/prosthetic/orthotic vendors. For verification of eligible equipment and supplies, contact Customer Service at the phone number shown on the inside cover of this *contract*.

We will provide coverage for only one of the following: a manual wheelchair, a motorized wheelchair, a knee walker, or a motorized scooter, as determined by *us* or *our* designee.

Payment is limited to the most cost effective and *medically necessary* alternative. *We* limit coverage to the standard model, as determined by *us* or *our* designee. When *you* purchase a model that is more expensive than what is considered *medically necessary* by *us* or *our* designee, *you* will be responsible for the difference in purchase and maintenance cost**.** *Our* payment for rental shall not exceed the purchase price, unless *we* have determined that the item is appropriate for rental only. *We* reserve the right to determine if an item will be approved for rental or purchase.

If *you* purchase new equipment or supplies when *we* or *our* designee determines that repair costs of *your* current equipment or supplies would be more cost effective, then *you* will be responsible for the difference in cost.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Any durable medical equipment or supplies not listed as eligible on *our* durable medical equipment list, or as determined by *us* or *our* designee.
c. Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
d. Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
e. Routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of a one-month rental billed every six months.
f. Replacement or repair of items when: 1) damaged or destroyed by misuse, abuse or carelessness; 2) lost; or 3) stolen.
g. Replacement of equipment unless *we* determine it is *medically necessary.*
h. Repair or replacement of durable medical equipment less than three years after original purchase, except for insulin pumps.
i. Repair or replacement of insulin pumps less than one year after original purchase.
j. Replacement of over-the-counter batteries.
k. Duplicate or similar items.

l. Devices and computers to assist in communication and speech, except for speech aid devices and tracheoesophageal voice devices as covered under this section of the *contract*.
m. Durable medical equipment that *we* determine to be for *your* comfort, personal hygiene, or convenience including, but not limited to, personal fitness equipment and self-help devices not medical in nature.
n. Continuous passive motion (CPM) devices and mechanical stretching devices.
o. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs and cryotherapy; and home automated external defibrillator (AED).
p. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
q. Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
r. Over-the-counter orthotics and appliances.
s. Orthopedic shoes and custom molded foot orthotics, unless *you* have diabetes or peripheral vascular disease.
t. Charges for sales tax, mailing and delivery.
u. Durable medical equipment necessary for the operation of equipment determined not to be eligible for coverage.
v. Durable medical equipment, orthotics and prosthetics necessary for activities beyond *activities of daily living.*
w. Durable medical equipment, orthotics and prosthetics that *we* determine to have special features that are not *medically necessary*.
x. Wigs, toupees, hairpieces, cranial prothesis, hair implants, hair transplants, hair weaving, or hair loss prevention treatments.
y. Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.
z. Blood pressure cuffs and monitors.
aa. Enuresis alarms.
bb. Trusses.
cc. Ultrasonic nebulizers.
dd. Oral appliances for snoring.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit, we* pay**:**
		Note: For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *non-participating provider reimbursement value.*

F. ***Emergency Services***		
• *Emergency services* provided in an emergency room.	100% of *eligible charges* after a *copayment* of $450 per visit for *emergency services* resulting in an emergency room charge. *Deductible* does not apply to the emergency room charge. **Note:** Some services that may be provided during an emergency room visit may be subject to the *deductible* such as, but not limited to, *physician* services, laboratory, pathology radiology and surgical procedures.	Same as the *participating provider benefit*.

You should be prepared for the possibility of a medical *emergency* by knowing *your participating provider's* procedures for "on call" and after regular office hours before the need arises. Determine the telephone number to call, which *hospital your participating provider* uses, and other information that will help *you* act quickly and correctly. Keep this information in an accessible location in case a medical *emergency* arises.

If *you* have an *emergency* situation that requires immediate treatment, call 911 or go to the nearest emergency facility. If possible under the circumstances, *you* should telephone *your physician* or the participating clinic where *you* normally receive care. A *physician* will advise *you* how, when and where to obtain the appropriate treatment.

Note: Non-*emergency services* received in an emergency room are not covered. If *you* choose to receive non-*emergency* health services in an emergency room, *you* are solely responsible for the cost of these services. See *emergency* under "Definitions."

You should provide notice to *us* of an *emergency* admission. However, if *you* are incapacitated in a manner that prevents *you* from providing notice of the admission within 48 hours or as soon as reasonably possible, or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the 48 hour time period begins when the incapacity is removed, or when *your* parent (or guardian) is made aware of the admission. *You* are considered incapacitated only when: 1) *you* are physically or mentally unable to provide the required notice; and 2) *you* are unable to provide the notice through another person.

If a *copayment* is shown, the *copayment* applies to the emergency room visit only. *We* will waive the emergency room visit *copayment* if *you* are admitted as a resident patient to the *hospital* directly from the emergency room. If *you* are placed in observation care directly from the emergency room, the emergency room visit *copayment*, if applicable, will be waived.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Non-*emergency services* received in an emergency room.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
G. Hearing Aids, Implantable Hearing Devices, and Related Treatment		
Any of the following for *members* who are certified as deaf or hearing impaired by a *provider* in accordance with accepted medical or audiological standards: a. One *hearing aid* (including fitting and testing), per ear, once every 3 years. b. *Implantable hearing devices.* c. *Health care services* related to covered *hearing aids* and *implantable hearing devices,* including procedures for the implantation of *implantable hearing devices.* d. Post-*cochlear implant* aural therapy.	70% of *eligible charges* after the *deductible.*	Not covered.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Hearing protection equipment.
c. *Hearing aid* batteries and cords.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
H. *Home Care* Services	Limited to 60 *home care* visits per *calendar year.* Each visit, up to 4-hours in duration, equals one visit and counts toward the maximum visits for *home care* services. Any visit that lasts less than 4 hours, regardless of the length of the visit, will count as one visit toward the maximum visits for *home care* services. All visits must be *medically necessary* and all charges for *home care* services must be *eligible charges* under the terms of this *contract*.	
Home care	70% of *eligible charges* after the *deductible.*	Not covered.

We cover skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy, and other therapeutic services, laboratory services, equipment, supplies and drugs, as appropriate, and other eligible home health services prescribed by a *physician* for the care and treatment of *your sickness* or *injury* and rendered in *your* home up to the visit limits listed above.

You must be *homebound* for care to be received in *your* home, unless *we* or *our* designee deems the care medically appropriate and/or determines that the care is more cost effective than care in a facility or clinic.

We cover *home care* services, including:

1. Home safety evaluations, evaluations for a home treatment program, and/or initial visit(s) to evaluate *you* for an independent treatment plan.
2. Part-time or intermittent home nursing care by or under supervision of a registered nurse.
3. 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.
4. Physical or occupational therapy or speech-language pathology or respiratory care.
5. Medical supplies and *prescription drugs* prescribed by an *attending health care professional* and laboratory services by or on behalf of a *hospital* if needed under the *home care* plan. These items are covered to the extent they would be if *you* had been confined in a *hospital*.
6. Nutrition counseling provided or supervised by a registered or certified dietician.
7. Evaluation of the need for a *home care* plan by a registered nurse, *physician* extender or medical social worker. *Your attending health care professional* must request or approve this evaluation.

A service will not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed, registered nurse. Where a service (such as a tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person, or self-administered, without the direct supervision of a licensed, registered nurse, the service will not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service does not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (i.e., service, that include skilled and non-skilled components) is covered.

We cover palliative care benefits if *you* are not *homebound*. Palliative care includes symptom management, education, and establishing goals of care.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Companion and home care services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
c. *Health care services* and other services provided as a substitute for a primary caregiver in the home.
d. *Health care services* and other services that can be performed by a non-medical person or self-administered.
e. *Health care services* and other services provided in *your* home for convenience.
f. *Health care services* and other services provided in *your* home due to lack of transportation.

g. *Custodial care*, except *home health aide services* as covered in this section.
h. *Health care services* and any other services at any site other than *your* home.
i. Recreational therapy.
j. Domiciliary Care, such as meals-on-wheels, health visiting, and home help, provided by a welfare agency for people in their homes.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
I. Hospice Care	70% of *eligible charges* after the *deductible.*	Not covered.

We cover hospice services provided to *you* during the initial six-month period immediately following the diagnosis of a terminally illness. *You* must meet the eligibility requirements and elect to receive services through a home hospice program. The services will be provided in *your* home, with inpatient care available when *medically necessary* as described below. If *you* elect to receive hospice services, *you* do so in lieu of curative or restorative treatment for *your* terminal illness for the period *you* are enrolled in the home hospice program.

Coverage for hospice care will be extended beyond the initial six-month period if an *attending health care professional* provides an updated certification in writing that *you* are terminally ill.

Prior authorization by *us* or *our* designee is recommended for hospice services.

1. **Eligibility.** In order to be eligible to be enrolled in the home hospice program, *you* must:

   a. be terminally ill with a *physician* certification that *you have* six months or less to live; and
   b. have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than restorative treatment or treatment attempting to cure the disease or condition).

   You may withdraw from the home hospice program at any time.

2. ***Covered Services***. Hospice services include the following services, provided in accordance with an approved hospice treatment plan:

   a. part-time (defined as up to two hours of service per calendar day) care in *your* home by an interdisciplinary hospice team (which might include a *physician*, nurse, social worker, and spiritual counselor) and home health aide services, if prior authorized by *us* or *our* designee.
   b. one or more periods of continuous care in *your* home or in a setting that provides day care for pain or symptom management, when *medically necessary*, as determined by *us* or *our* designee.
   c. *medically necessary* inpatient services.
   d. respite care for caregivers in *your* home or in an appropriate setting. Respite care should be prior authorized by *us* or *our* designee, to give *your* primary caregivers (i.e., family *members* or friends) rest and/or relief when necessary in order to maintain *you* at home.
   e. *medically necessary* medications for pain and symptom management, if prior authorized by *us* or *our* designee.
   f. *hospital* beds and other durable medical equipment when *medically necessary* and should be prior authorized by *us* or *our* designee.

Continuous care is defined as two to 12 hours of service per calendar day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain *you* in *your* home when *you* are terminally ill.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Health care services* and other services provided by *your* family or a person who shares *your* legal residence.
c. Respite or rest care, except as specifically described in this section.

Benefit	***Participating Provider Benefit, we* pay*:***	***Non-Participating Provider Benefit, we* pay:** **Note:** For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *non-participating provider reimbursement value.*
J. *Hospital* Services		
• Inpatient *Hospital* Services. • Inpatient *hospital* and *residential treatment facility* services for mental and substance use disorders. • Outpatient *hospital* services, ambulatory care or surgical facility services. • Outpatient *hospital*, partial *hospital*, and rehabilitation services in a day *hospital* program for mental and substance use disorders. • Cardiac Rehabilitation Services, including inpatient Phase I and up to 36 visits for outpatient Phase II. • Cognitive Rehabilitation Therapy, up to 20 outpatient visits per *calendar year*. • Pulmonary Rehabilitation Therapy, up to 24 outpatient visits per *calendar year*. • Telemedicine. • *Medically necessary* genetic testing determined by *us* to be *covered services*, as described below: ✓ *You* display clinical features, or are at direct risk of inheriting the mutation in question (presymptomatic); and ✓ The result of the test will directly impact the current treatment being delivered to *you*; and ✓ After history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.	70% of *eligible charges* after the *deductible.*	**For *Medically necessary* inpatient hospital stays that are the result of an *emergency* admission, until the *member* can be stabilized and transferred:** Same as the *participating provider benefit*. **All other *Hospital Services* from *Non-Participating Providers*:** Not covered.

Notify *us* of *your* admission to an inpatient facility within 48 hours or as soon as medically possible.

In determining maternity benefits for professional and *hospital* services for delivery and postnatal care, each *member's confinement*, including that of a newborn child, is separate and distinct from the *confinement* of any other *member*.

1. **Inpatient Services.** *We* cover services and supplies for the treatment of acute *sickness* or *injury* that requires the level of care only available in an *acute care facility*. Inpatient services include, but are not limited to:

   a. room and board;
   b. the use of operating rooms, intensive care facilities, and newborn nursery facilities;
   c. general nursing care, anesthesia, radiation therapy, physical, speech and occupational therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related *hospital* services;
   d. *physician* and other professional medical and surgical services;
   e. mental health and substance use disorder services, including detoxification services;
   f. diagnostic imaging and laboratory tests and pathology; and
   g. professional medical and surgical services provided by an assistant surgeon, which is defined as a certified *physician* assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant, certified registered nurse first assistant, certified nurse midwife, or a *physician*.

We cover a semi-private room, unless a *physician* recommends that a private room is *medically necessary* and so orders. In the event a *member* chooses to receive care in a private room under circumstances in which it is not *medically necessary*, *our* payment toward the cost of the room shall be based on the average semi-private room rate in that facility. *We* or *our* designee will determine if a private room meets *medically necessary* criteria.

2. **Outpatient *Hospital*, Ambulatory Surgery Center Care, or Surgical Facility Services.** *We* cover the following services and supplies, for diagnosis or treatment of *sickness* or *injury* on an outpatient basis:

   a. use of operating rooms or other outpatient departments, rooms or facilities;
   b. the following outpatient services: general nursing care, anesthesia, radiation therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related outpatient services;
   c. laboratory tests, pathology and radiology;
   d. *physician* and other professional medical and surgical services rendered while an outpatient;
   e. mental health and substance use disorder services;
   f. professional medical and surgical services provided by an assistant surgeon, which is defined as a certified *physician* assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant, certified registered nurse first assistants, certified nurse midwives, or a *physician*; and
   g. Telemedicine services which may include interactive audio and video communications, permitting real time communication between a distant site *provider* of *health care services* and the *member*.

   We also cover *preventive health care services*. These services will be covered as shown in the *Preventive Health Care Services*, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *contract*.

3. **Rehabilitation Services in a Day *Hospital* Program.** *We* cover rehabilitation services in a day *hospital* program. Coverage is limited to services for *rehabilitative care* in connection with a *sickness* or *injury*.

4. **Cardiac Rehabilitation Services.** *We* cover the following cardiac rehabilitation services:

   a. Phase I cardiac rehabilitation sessions while *you* are confined as an inpatient in a *hospital;* and
   b. Up to 36 supervised and monitored Phase II cardiac rehabilitation sessions per covered *sickness* while *you* are an outpatient receiving services in a facility with a facility-approved cardiac rehabilitation program.

5. **Cognitive Rehabilitation Therapy.** *We* cover outpatient cognitive rehabilitation therapy following a brain *injury* or cerebral vascular accident limited to 20 visits per *calendar year*.

6. **Pulmonary Rehabilitation.** *We* cover outpatient pulmonary rehabilitation therapy limited to 24 visits per covered *sickness* per calendar year.

7. **Court-Ordered Services**. *We* cover mental health evaluations and treatment ordered by a Wisconsin court under a valid court order when the services ordered are covered under this *contract* and:

   a. The court-ordered behavioral care evaluation is performed by a *participating provider* or other *provider* as required by law and the *provider* is a licensed psychiatrist, or doctoral level licensed psychologist.
   b. The treatment is provided by a *participating provider* or other *provider* as required by law and is based on a behavioral care evaluation that meets the criteria of a. above and includes a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

   We must receive a copy of any court order and evaluation. *We* or *our* designee may make a motion to modify a court ordered plan and may request a new behavioral care evaluation.

Emergency Services that Lead to an Inpatient Admission

You should provide notice to *us* of an *emergency* admission. However, if *you* are incapacitated in a manner that prevents *you* from providing notice of the admission within 48 hours or as soon as reasonably possible, or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the 48 hour time period begins when the incapacity is removed, or when *your* parent (or guardian) is made aware of the admission. *You* are considered incapacitated only when: 1) *you* are physically or mentally unable to provide the required notice; and 2) *you* are unable to provide the notice through another person.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

When coverage is applicable, under state law, health insurance issuers offering health insurance coverage as specified below may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the health insurance issuer may pay for a shorter stay if the attending *provider* (e.g., *your physician*, nurse midwife, or *physician* assistant), after consultation with and mutual agreement by the mother, discharges the mother or newborn earlier.

Also, health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a health insurance issuer may not require that a *physician* or other health care *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Travel, transportation, other than ambulance transportation, or living expenses.
c. Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
d. Non-*emergency* ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
e. *Health care services* to treat conditions *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom.
f. Orthoptics and surgery for refractive conditions correctable by contacts or glasses (i.e., Lasik surgery).
g. *Health care services* for gender reassignment, except when *medically necessary*.
h. Genetic testing and associated *health care services*, except as covered under this *contract.*
i. Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
j. Routine foot care, unless required due to diabetes or peripheral vascular disease.
k. Autopsies.
l. *Bariatric surgeries,* including preoperative procedures, initial procedures, surgical revisions and subsequent procedures.
m. *Health care services* or items for personal convenience, such as television rental.
n. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
o. Nutritional counseling, except when provided:
   1) During a *confinement*; or
   2) As outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or
   3) In a *physician's* office, clinic system or *hospital* setting to a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
   4) As counseling that is treated as a *preventive health care service.*

p. Marital counseling, relationship counseling, family counseling except as covered under this *contract*, or other similar counseling or training services.
q. Services to hold or confine a *member* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
r. Counseling, studies, *confinements*, *health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by *us* or *our* designee, except as covered under this *contract*.
s. Cardiac rehabilitation beyond Phase II.
t. Visits in excess of stated limits for cardiac, cognitive or pulmonary rehabilitation.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
K. *Infertility* Services • Diagnostic services. • Treatment to correct underlying causes of *infertility*.	70% of *eligible charges* after the *deductible.*	Not covered.

We cover professional services necessary to diagnose *infertility* and the related tests, facility charges, and laboratory work related to the diagnosis. *We* also cover *health care services* required to treat or correct the underlying causes of *infertility* (e.g. blocked fallopian tube, endometriosis).

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Reversal of voluntary sterilization.
c. Adoption costs.
d. *Health care services* associated with expenses for *infertility,* including assisted reproductive technology, except for those services related to a covered medical condition.
e. Direct attempts to achieve pregnancy or increase chances of pregnancy by any means.
f. Any laparascopic procedure during which an ovum is manipulated or the purpose of *fertility treatment* even if the laparoscopic procedure includes other purposes.
g. Gamete intrafallopian transfer (GIFT) procedures.
h. Zygote intrafallopian transfer (ZIFT) procedures.
i. Intracytoplasmic sperm injection (ICSI).
j. In-vitro fertilization.
k. *Health care services* related to surrogate pregnancy for a person who is not a *member* under this *contract.*
l. Artificially assisted technology, such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
m. Sperm, ova or embryo acquisition, retrieval or storage.
n. *Prescription drugs* for which the primary purpose is to preserve *fertility*.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
L. Office Visits		
• *Sickness or injury* – Primary care, *specialist* and other practitioner (nurse, *physician*) office visits related to diagnosis, care or treatment of a medical, mental health or substance use related condition, *sickness* or *injury.* • Telemedicine. • Allergy visits. **Note:** Some services that may be provided during an office visit may be subject to the *deductible* such as, but not limited to, laboratory, pathology radiology, surgical procedures, and allergy testing and injections.	**Primary Care:** 100% of *eligible charges* after a *copayment* of $35 per visit. *Deductible* does not apply. **Specialist:** 100% of *eligible charges* after a *copayment* of $70 per visit. *Deductible* does not apply.	Not covered.
• Diagnostic imaging, including magnetic resonance imaging and computing tomography, laboratory tests and pathology.	70% of *eligible charges* after the *deductible.*	Not covered.
• Surgical Services.	70% of *eligible charges* after the *deductible.*	Not covered.
• *Web based (online) care.*	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• *Convenience Care Center.*	100% of *eligible charges* after a *copayment* of $10 per visit. *Deductible* does not apply.	Not covered.
• *Urgent Care Center*.	100% of *eligible charges* after a *copayment* of $35 per visit. *Deductible* does not apply.	Same as the *participating provider benefit*.
• Allergy injections with no office visit.	70% of *eligible charges* after the *deductible.*	Not covered.

• *Medically necessary* genetic testing determined by *us* to be *covered services*, as described below: ✓ *You* display clinical features, or are at direct risk of inheriting the mutation in question (presymptomatic); and ✓ The result of the test will directly impact the current treatment being delivered to *you*; and ✓ After history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.	70% of *eligible charges* after the *deductible.*	Not covered.

We cover the professional medical and surgical services of licensed *physicians*, health care *providers* and nurses.

1. Services are provided for the following:
   a. Office visits relating to the diagnosis, care or treatment of a condition, *sickness* or *injury*.
   b. Treatment of diagnosed Lyme disease.
   c. Contact lenses and their related fittings are not eligible for coverage for adults over age 18 unless they are prescribed as *medically necessary* for the treatment of keratoconus. If prescribed for keratoconus, *your* first set of contact lenses and their fitting are *eligible charges* under the DME benefit. *You* must pay for lens replacement.
   d. Diagnostic imaging (such as X rays, CT/PET scans, MRIs), laboratory tests, and pathology.
2. Outpatient professional services for evaluation, diagnosis, crisis intervention, therapy, including *medically necessary* group therapy, psychiatric services, treatment of a minor (including family therapy but only for treatment of a minor),and treatment of mental and nervous disorders.
3. Diagnosis and treatment of substance use disorders, including evaluation, diagnosis, therapy and psychiatric services.
4. Allergy testing and injections.
5. Surgical services performed in the office, including but not limited to:
   a. *Oral surgery* for: 1) treatment of oral neoplasms and non-dental cysts; 2) fracture of the jaws; and 3) trauma of the mouth and jaws.
   b. Surgical and non-surgical treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD) that is *medically necessary*.
6. Diabetic outpatient self-management training and education, including medical nutrition therapy received from a *provider* working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.
7. An *emergency* examination of a child ordered by judicial authorities.
8. Court-Ordered Services. *We* cover mental health evaluations and treatment ordered by a Wisconsin court under a valid court order when the services ordered are covered under this *contract* and:
   a. The court-ordered behavioral care evaluation is performed by a *participating provider* or other *provider* as required by law and the *provider* is a licensed psychiatrist, or doctoral level licensed psychologist.
   b. The treatment is provided by a *participating provider* or other *provider* as required by law and is based on a behavioral care evaluation that meets the criteria of a. above and includes a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

   We must receive a copy of any court order and evaluation. *We* or *our* designee may make a motion to modify a court ordered plan and may request a new behavioral care evaluation.

9. Telemedicine services which may include interactive audio and video communications, permitting real time communication between a distant site *provider* of *health care services* and the *member*, who is present and participating in the televideo visit at a remote *provider* office.

We also cover *preventive health care services*. These services will be covered as shown in the *Preventive Health Care Services*, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *contract* and not this section of the *contract*.

Exclusions:

a. Please see the section entitled Exclusion List.
b. Health education, except when:
   1) Provided during an office visit for non-*preventive health care services*; or
   2) It is counseling that is treated as a *preventive health care service.*
c. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
d. Nutritional counseling, except when provided:
   1) During a *confinement*; or
   2) As outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or
   3) In a *physician's* office, clinic system or *hospital* setting to a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
   4) As counseling that is treated as a *preventive health care service*.
e. Marital counseling, relationship counseling, family counseling except as covered under this *contract*, or other similar counseling or training services.
f. Professional sign language and foreign language interpreter services in a *provider's* office.
g. Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or treated as a *preventive health care service*.
h. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by *us* or *our* designee.
i. Genetic testing and associated *health care services*, except as covered under this *contract*.
j. Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
k. Routine foot care, unless required due to diabetes or peripheral vascular disease.
l. Vision therapy/Orthoptics.
m. Counseling, studies, or services ordered by a court or law enforcement officer that are not determined to be *medically necessary*, except as covered under this *contract*.
n. Nutritional and food supplements.

Benefit	*Designated Transplant Network Provider, we* **pay:**	*Non-Designated Transplant Network Provider*
M. Organ and Bone Marrow *Transplant Services*	**Office visits:** See "Office Visits" section of this *contract.* ***Hospital* services:** See "*Hospital* Services" section of this *contract.*	Not covered.

We cover eligible *transplant services* that *we* or *our* designee determines to be *medically necessary* and not *investigative* but only when the *transplant services* are received at a *designated transplant network provider*. Prior Authorization by *Aspirus* or its designee is recommended in advance or receiving *transplant services*.

Coverage for organ transplants, bone marrow transplants, and bone marrow rescue services is subject to periodic review. *We* evaluate *transplant services* for therapeutic treatment and safety. This evaluation continues at least annually, or as new information becomes available, and it results in specific guidelines about benefits for *transplant services*. *You* may call Customer Service at the telephone number listed inside the cover of this *contract* for information about these guidelines.

If the transplant meets the definition of an *eligible charge*, is *medically necessary*, and is not *investigative*, benefits are available for the following eligible transplants:

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

We will cover approved *transplant services*, including but not limited to *organ and tissue acquisition* and transplantation, including any post-transplant complications, if *you* are the recipient; and related medical care, including any post-harvesting complication, if *you* are a donor. Transplant coverage includes a private room and all related post-surgical treatment and drugs. The transplant-related treatment provided shall be subject to and in accordance with the provisions, limitations and other terms of this *contract.*

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Transplant services* received from a *provider* that is not a *designated transplant network provider*.
c. *Health care services* related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are *investigative* for *your* diagnosis or condition.
d. *Health care services*, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by *us* or *our* designee.
e. *Health care services*, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.
f. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
g. Computer search for donors.

h. Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
i. Travel expenses related to a covered transplant.
j. *Health care services* for or in connection with fetal tissue transplantation, except for non-investigative stem cell transplants.
k. Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of US Food and Drug Administration (FDA) approved ventricular assist devices and transplants of artificial or mechanical devices as a bridge to a transplant or destination therapy.

Benefit	*Non-Participating Provider Benefit*
	for *non-participating providers* located in Wisconsin and within reasonable proximity to the school in which the student is enrolled.

N. Outpatient Behavioral Health Services for Full-Time Students	
Clinical assessment of a mental or nervous disorder or substance use disorder of a covered dependent child who is attending school outside of the *geographic service area*, but within Wisconsin. Up to 5 outpatient visits for mental or nervous disorders or substance use disorders if outpatient *health care services* are recommended based on the clinical assessment of such child. Prior approval from *us* is required for continuing care after the first five visits.	**Outpatient *Hospital* visits:** 70% of *eligible charges* after the *deductible* **Office visits:** **Primary Care:** 100% of *eligible charges* after a *copayment* of $35 per visit. *Deductible* does not apply. **Specialist:** 100% of *eligible charges* after a *copayment* of $70 per visit. *Deductible* does not apply.

NOTE: For coverage of behavioral health services from *participating providers* or for *members* who are not full-time students, please refer to the sections entitled "*Hospital* Services" and "Office Visits".

A limited benefit for outpatient *health care services* received from *non-participating providers* is available for a covered dependent child who is attending school outside of the *geographic service area*, but within Wisconsin.

Prior to receiving *health care services* under this section, such student must undergo a clinical assessment. If outpatient *health care services* are recommended in the clinical assessment, no more than five visits to a *non-participating provider* outpatient treatment facility or other *non-participating provider* will be payable.

Upon completion of the five visits, continuing care by the *non-participating provider* must be approved by *us*.

All *non-participating provider* outpatient treatment facilities or other *non-participating providers* must be located in Wisconsin and within reasonable proximity to the school in which the student is enrolled.

For purpose of this section, school means a vocational, technical, or adult education school; a center or institution in the University of Wisconsin system; and any institution of higher education that grants a bachelor's or higher degree.

Exclusions:

a. Please see the section entitled "Exclusion List."

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
O. Physical Therapy, Occupational Therapy and Speech Therapy		
• Physical Therapy, up to 20 visits for *rehabilitative care* and 20 visits for *habilitative therapy*.	100% of *eligible charges* after a *copayment* of $35 per visit. *Deductible* does not apply.	Not covered.
• Occupational Therapy, up to 20 visits for *rehabilitative care* and 20 visits for *habilitative therapy.*	100% of *eligible charges* after a *copayment* of $35 per visit. *Deductible* does not apply.	Not covered.
• Speech Therapy, up to 20 visits for *rehabilitative care* and 20 visits for *habilitative therapy*.	100% of *eligible charges* after a *copayment* of $35 per visit. *Deductible* does not apply.	Not covered.

We cover office visits and outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for *rehabilitative care* rendered to treat a medical condition, *sickness* or *injury*, and the *rehabilitative care* is expected to demonstrate measurable and sustainable improvement within 2 weeks to 3 months, depending on the physical and mental capacities of the individual. *We* also cover office visits and outpatient PT, OT and ST *habilitative therapy* for medically diagnosed conditions. PT, OT and ST must be provided by or under the direct supervision of a licensed physical therapist, occupational therapist or speech therapist for appropriate services within their scope of practice. OT and ST must be ordered by a *physician, physician's* assistant or certified nurse practitioner.

NOTE: Benefits for *health care services* administered or received in an inpatient setting are described in the "*Hospital* Services" section of this *contract.* Benefits for *skilled care* administered or received in a *skilled nursing facility* are described in the "*Skilled Nursing Facility* Care" section of this *contract*.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Custodial care* or *maintenance care*.
c. Therapy provided in *your* home for convenience.
d. Therapy for conditions that are self-correcting.
e. Voice training and voice therapy absent a medical condition.
f. *Investigative* therapies.
g. Group therapy for physical therapy, occupational therapy and speech therapy.
h. *Investigative* therapies for the treatment of autism, such as secretin infusion therapies.
i. *Health care services* for homeopathy and immunoaugmentive therapy.

Benefits	Drugs obtained at a pharmacy that is a *participating provider, we* pay:	Drugs obtained at a pharmacy that is <u>not</u> a *participating provider*
P. *Prescription Drug* Services	**Note:** Benefits for *specialty drugs* are as described in this section regardless of the place of service where the *specialty drug* is dispensed or administered. Please see the *Preventive Health Care Services* section for coverage of *prescription drugs*, including certain insulin and other glucose lowering agents, on *our* Preventive Drug List.	
• *Prescription drugs* that can be self-administered and supplies dispensed by a participating pharmacy for up to a 90-calendar day supply per prescription or refill.	**<u>Up to 30 day Supply</u>** **Tier 1:** 100% of *eligible charges* after a *copayment* of $20 per prescription or refill. *Deductible* does not apply. **Tier 2:** 100% of *eligible charges* after a *copayment* of $40 per prescription or refill. *Deductible* does not apply. **Tier 3:** 100% of *eligible charges* after a *copayment* of $70 per prescription or refill. *Deductible* does not apply. **Non-*formulary*:** Not covered. **<u>31-90 day Supply</u>** **Tier 1:** 100% of *eligible charges* after a *copayment* of $50 per prescription or refill. *Deductible* does not apply. **Tier 2:** 100% of *eligible charges* after a *copayment* of $100 per prescription or refill. *Deductible* does not apply. **Tier 3:** 100% of *eligible charges* after a *copayment* of $175 per prescription or refill. *Deductible* does not apply. **Non-*formulary*:** Not covered.	Not covered.

• Mail order *prescription drugs* and supplies dispensed by a participating pharmacy for up to a 90-calendar day supply per prescription or refill.	**Up to 30 day Supply** **Tier 1:** 100% of *eligible charges* after a *copayment* of $20 per prescription or refill. *Deductible* does not apply. **Tier 2:** 100% of *eligible charges* after a *copayment* of $40 per prescription or refill. *Deductible* does not apply. **Tier 3:** 100% of *eligible charges* after a *copayment* of $70 per prescription or refill. *Deductible* does not apply. **Non-*formulary*:** Not covered. **31-90 day Supply** **Tier 1:** 100% of *eligible charges* after a *copayment* of $50 per prescription or refill. *Deductible* does not apply. **Tier 2:** 100% of *eligible charges* after a *copayment* of $100 per prescription or refill. *Deductible* does not apply. **Tier 3:** 100% of *eligible charges* after a *copayment* of $175 per prescription or refill. *Deductible* does not apply. **Non-*formulary*:** Not covered.	Not covered.

Specialty Drugs		
Benefits	***Specialty Drugs* obtained at *our* designated specialty pharmacy, *we* pay:** For more information, contact Customer Service. **NOTE:** Certain *specialty drugs* may only be available by limited distribution through the manufacturer's select specialty pharmacy and may not be available through *our* designated specialty pharmacy. Benefits for such limited distribution *specialty drugs* will be paid the same as if they were obtained from *our* designated specialty pharmacy.	***Specialty Drugs* obtained at any pharmacy other than a designated specialty pharmacy**
• *Specialty drugs* up to a 30–calendar day supply per prescription or refill that: ✓ may be oral or injectable; and ✓ Must be purchased through a specialty pharmacy. A list of these *specialty drugs* may be obtained on the designated website or by calling Customer Service. The list of *specialty drugs* may be revised from time-to-time without notice.	60% of *eligible charges* after application of a separate $650 *specialty drug deductible* per *calendar year*. The *specialty drug deductible* is separate from, and in addition to, the *deductible* shown in Section VII – Schedule of Payments. **Non-*formulary*:** Not covered.	Not covered.

Preventive Contraceptives. This section does not cover or provide benefits for oral, injectable, insertable *prescription drugs* and devices that are *preventive health care services* described in the "Preventive Contraceptive Methods and Counseling for Women" section of this *contract.*

Formulary. *We* use a drug *formulary* to determine which benefit level applies to a specific *prescription drug*. The *formulary* is subject to periodic review by *our* Pharmacy and Therapeutics Quality Subcommittee and modification by *us*, including at the start of or during the plan year. A current list of drugs on *our formulary* for individual plans may be obtained by accessing *our* website at https://www.aspirushealthplan.com or by calling Customer Service. *We* will provide reasonable advance notice to *you* if, during the plan year, a *prescription drug* which *you* have previously received during such plan year and which *we* have previously considered to be an *eligible charge* under this *contract* is removed from the *formulary* or if such *prescription drug* is placed in a higher cost-sharing tier during the plan year. *You* have a right to appeal the decision or to request an exception to gain access to a non-*formulary* drug when clinically appropriate and not otherwise covered under this *contract*. Refer to the section entitled "Internal Appeals Process" for details on how to appeal. Refer to the paragraphs entitled "Exceptions" below for details on how to request an exception.

Step Therapy. For certain medical conditions, there is a need to manage the use of specific drugs before alternative (second line) drugs are prescribed for the same medical condition. This is known as step therapy. *Members* in a step therapy program will need to meet the requirements of that program prior to receiving the second line drug. *You* may learn more about the program requirements on *our* website or by calling Customer Service. Step therapy can apply to *formulary* or non-*formulary* drugs and brand or generic drugs. The Step Therapy List is subject to periodic review and modification by *us*.

Quantity Limits. Some dispensed *prescription drugs* require the use of quantity limits, which ensure that the quantity of each prescription remains consistent with clinical guidelines. Quantity limits can apply to *formulary* or non-*formulary* drugs, and brand or generic drugs. A list of those *prescription drugs* with quantity limits is available upon request. The quantity limits list is subject to periodic review and modification by *us.*

Eye Drop Refills. Refills of prescribed eye drops are covered if the refill is requested by the *member* covered under this *contract* and the prescribing *provider* indicates that refills are required. Coverage for such eye drop refill will only be provided if *you* make a refill request when 75 percent or more of the days have elapsed from the later of the original date the prescription was dispensed or the date of the most recent refill.

Brand Name Drugs for which Generic Available. If *you* or *your provider* request a brand name drug when a generic drug alternative is available, *you* must pay the applicable *coinsurance* for the brand name drug plus the difference in cost between the brand name and the generic drug.

Biosimilar Drugs. If all of the following apply:

1. *you* or *your provider* request a *specialty drug* that is a biological product licensed by the FDA under section 351 of the Public Health Service Act (PHS Act), and
2. the FDA has determined another biological product to be biosimilar to the *specialty drug* that has been requested by *your provider*, and
3. *we* have included such biosimilar drug on *our* list of approved biosimilar drugs in relation to the *specialty drug* that has been requested by *your provider*;

then *you* must pay the applicable *deductible* or *coinsurance* for the *specialty drug* requested by *your provider* plus the difference in cost between the *specialty drug* requested by *your provider* and the biosimilar product that is on *our* list of approved biosimilar drugs.

Exceptions: *You* or *your provider* may request an exception to the drug *formulary*. *We* must make a determination on a standard exception request and notify *you* and the prescribing *physician* of *our* coverage determination no later than 72 hours following receipt of the request. Upon request, *we* will perform an expedited review of the exception request if *you* are suffering from a health condition that may seriously jeopardize *your* life, health, or ability to regain maximum function, or when *you* are undergoing a current course of treatment using a non-*formulary* drug. If *we* determine *you* qualify for an expedited review of the exception request based on these criteria, *we* must make a determination on the expedited exception request and notify *you* and the prescribing *physician* of *our* coverage determination no later than 24 hours following receipt of the request. *We* will determine if an exception applies and, if so, the non-*formulary* drugs that are approved as an exception will be covered at the same level as the *formulary* drugs.

If *your* request for a *formulary* exception is denied, *you* have a right to request that *your formulary* exception request be reviewed by an independent review organization that is not associated with *us*. This right to request external review of a *formulary* exception request is separate from *your* right to request external review as described in the External Review Process section and only applies to denials of a *formulary* exception request and only after *your formulary* exception request has been reviewed in accordance with the preceding paragraph and denied. When *you* request an external review of a *formulary* exception request, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision. If *your formulary* exception request is complete and eligible for external review, *we* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization. If the original *formulary* exception request was a standard exception request, *you* will be notified of the results of the external review within 72 hours following receipt of the request. If the original *formulary* exception request was an expedited exception request, *you* will be notified of the results of the external review within 24 hours following receipt of the request.

An exception is valid for the duration of the prescription while covered under this *contract*, including refills, except that if *you* obtained an exception based on an expedited review the exception will be valid for the duration of the circumstances that are the basis for the expedited review. *Your physician* may request the exception for subsequent prescriptions, following the procedure described above. The exception does not apply if *we* removed the drug from the *formulary* for safety reasons. Contact Customer Service for a copy of the written guidelines and procedures, or for assistance in requesting an exception.

Compounded Drugs. *Compounded drugs* will be covered provided that at least one active ingredient is a *prescription drug*. Payment for a *compounded drug* that has a commercially prepared product available that is identical to or similar to the *compounded drug* will be considered for coverage after documented failure of the commercially prepared product(s), unless a *formulary* exception is obtained. A commercially prepared product is one that is available at the pharmacy in its final, usable form and does not need to be compounded at the pharmacy. The applicable *formulary* benefit level will be applied. *Compounded drugs* containing any product that is excluded by *us* will not be covered, including dosages and route of administration that have not been approved by the FDA.

Prescription Drugs* covered as *Preventive Health Care Services. *We* cover certain *prescription drugs* which are required to be covered without cost-sharing as *preventive health care services* under the *Affordable Care Act. Our formulary* identifies these *prescription drugs* as being included in the "$0 Cost Share" tier and may be obtained by accessing *our* website at www.aspirushealthplan.com or by calling Customer Service. More information regarding benefits for *prescription drugs*

that are *preventive health care services* can be found under the "Preventive Contraceptive Methods and Counseling for Women" and "*Preventive Health Care Services*" sections of this *contract.*

Off-label use of drugs. Off-label use of drugs, provided they are not *investigative,* are covered when:

1. A drug is recognized as appropriate for cancer treatment in a *standard reference compendia* such as the National Comprehensive Cancer Network Drugs and Biologics Compendium or one article in the *medical literature*; or
2. A drug is deemed appropriate for its proposed use by any authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case-reports.

Prior Authorization. Certain *prescription drugs* may require prior authorization before *you* can have *your* prescription filled at the pharmacy. These *prescription drugs* may include, but are not limited to:

1. *Compounded drugs* that are over $200.
2. *Specialty drugs.*

For more information, please call the phone number listed on the inside front cover of this *contract.*

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Prescription drugs* obtained from a pharmacy that is a *non-participating provider.*
c. Replacement of a *prescription drug* due to loss, damage, or theft.
d. Drugs available over-the-counter (OTC), except prescribed OTC drugs that are required to be covered as *preventive health care services* under the *Affordable Care Act* as covered under the "Preventive Contraceptive Methods and Counseling for Women" or "*Preventive Health Care Services*" sections of this *contract*.
e. *Prescription drugs* equivalent to or similar to OTC drugs, except as covered under this *contract.*
f. OTC home testing products, except as covered under this *contract.*
g. Drugs not approved by the FDA and drugs not approved by the FDA for a particular use, except off-label drugs used for the treatment of cancer or when *we*, at *our* sole discretion, determine to include the drug on *our formulary* or approve coverage of the drug for the particular use.
h. Take home drugs when dispensed by a *physician.*
i. Weight loss drugs.
j. Prescriptions written by a *dentist* unless in connection with dental procedures covered under this *contract.*
k. Drugs used for *cosmetic* purposes.
l. Unit dose packaging.
m. *Prescription drugs* for which the primary purpose is to preserve *fertility*.
n. Non-FDA approved route of administration (e.g. drug that is FDA approved for oral use but is being applied topically).
o. *Prescription drugs* given or administered as part of a drug manufacturer's study.
p. *Prescription drugs* if purchased by mail order through a program not administered by *our* pharmacy vendor.
q. *Prescription drugs* for the treatment of sexual dysfunction.
r. Off-label use of drugs determined to be *investigative.*
s. Certain *combination drugs* and other drugs if they are listed as not covered on the *formulary*.
t. *Compounded drugs* that are being used for bio-identical hormone replacement therapy, except as otherwise covered under this *contract.*
u. Oral, injectable and insertable contraceptives and contraceptive devices, except when covered for a medical condition or as a *preventive health care service* in the "Preventive Contraceptive Methods and Counseling for Women" section of this *contract.*
v. Prescribed or non-prescribed vitamins or minerals, including over-the-counter, unless covered as *preventive health care services.*
w. All medicinal foods, enteral feedings, supplemental feedings, nutritional and electrolyte supplements, and infant formula.
x. *Specialty drugs* obtained at any pharmacy other than *our* designated specialty pharmacy, except limited distribution *specialty drugs* only available through the manufacturer's select specialty pharmacy and not available through *our* designated specialty pharmacy.

y. Non-*formulary* drugs, unless an exception is obtained from *us.*
z. Any portion of a charge for a *prescription drug* which *you* are not required to pay or for which *you* receive reimbursement due to use of a manufacturer's coupon, rebate or other program that alters the amount *you* are legally obligated to pay, and/or waives any *coinsurance* or *deductible* that *you* are required to pay under this *contract*, except as required under state or federal law.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
Q. Preventive Contraceptive Methods and Counseling for Women		
We cover preventive contraceptive methods and counseling services received during the *calendar year* by female *members* as described in the Preventive Health Care Services Schedule ("Schedule") and according to the frequency and time frames stated in the Schedule. The Schedule, which includes the preventive contraceptive methods and counseling services for women provided by the *Affordable Care Act*, is available on *our* website at www.aspirushealthplan.com or by calling Customer Service. This coverage includes the full range of Food and Drug Administration approved contraceptive methods for women with reproductive capacity, including women's contraceptive drugs, devices, and delivery methods obtained from a retail pharmacy, a mail order pharmacy, or received at a *provider's* office.		
Women's prescription contraceptives received at a retail pharmacy or mail order pharmacy:		
• Generic oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and • Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	100% of the amount that would have been payable for the generic alternative. *Deductible* does not apply. If *you* or *your provider* request a brand name contraceptive when a generic alternative exists, *you* must pay the difference in cost between the brand name and the generic drug	Not covered.
Women's prescription contraceptives, sterilization procedures, and *member* education received at a *provider's* office:		
• Generic injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and • Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.

• Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	70% of *eligible charges* after the *deductible.*	Not covered.
• Sterilization procedures, excluding the reversal of sterilization procedures.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• *Member* education and counseling about contraceptive methods.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.

Your provider may request an exception for coverage with no cost sharing for a brand name drug for which a generic drug is available. *Your provider* or *you* may contact Customer Service for a copy of the written guidelines and procedures or for assistance in requesting an exception.

If the exception is approved, *we* will pay 100% of the *eligible charges* for the brand name preventive contraceptive drug when *you* obtain it from a *participating provider*, and the *deductible* will not apply.

An exception is valid for the duration of the prescription while *you* are covered under this *contract*, including refills. *Your provider* may request an exception for subsequent prescriptions following the procedure described in the *Prescription Drug* Services section. The exception does not apply if *we* remove the drug from the *formulary* for safety reasons. A previously granted exception ends when *we* remove the drug from the *formulary* for safety reasons.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Contraceptives and related *health care services* received from *non-participating providers*.
c. Sterilization procedures performed by *non-participating providers*.
d. Abortions are not covered under this section of this *contract.*
e. Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
f. Hysterectomies are not covered under this section of this *contract*.
g. Anesthesia and facility services related to sterilization procedures that are performed during other surgical procedures including, but not limited to, Cesarean section birth, gall bladder removal, and abdominal hernia repair, are not covered under this section of this *contract*.
h. Reversal of sterilization procedures.
i. Non-*preventive health care services* are not covered under this section of this *contract*.

Benefit	***Participating Provider Benefit, we* pay*:***	***Non-Participating Provider Benefit***
R. *Preventive Health Care Services*		
We cover *preventive health care services* required under the *Affordable Care Act* that *you* receive during the *calendar year.* The services required by the *Affordable Care Act* and their frequency and time frames are stated in the *Preventive Health Care Services* Schedule ("Schedule"). The Schedule may be amended from time-to-time, on a prospective basis, and is available on *our* website at www.aspirushealthplan.com or by contacting Customer Service. This *contract* also covers certain *preventive health care services* that are required by state law. They are addressed at the end of this section.		
The Schedule includes certain routine services such as: • Counseling for certain conditions and lactation counseling. • Routine laboratory tests, pathology and radiology. • Routine physical examinations when ordered by a *physician.* • Purchase/rental of breast pumps. • Certain prescribed preventive medications required under the *Affordable Care Act*. • Pap tests. • Routine screenings for certain other conditions (such as abdominal aortic aneurysm, diabetes, HIV and osteoporosis).	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• Routine immunizations.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• Colorectal screening tests for men and women including colonoscopy and associated *medically necessary health care services.*	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• Mammograms, including digital breast tomosynthesis.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.

• Tobacco cessation intervention programs: - Two designated tobacco cessation counseling program attempts per *member* per *calendar year*, limited to four counseling sessions per attempt; - Tobacco cessation *prescription drugs* and prescribed over-the-counter (OTC*)* medications when used in connection with or separate from a designated tobacco cessation counseling program, are limited to a maximum of 30-calendar days per prescription or refill per *member* and a total 90-calendar day supply per *member* per attempt for up to two attempts per *member* per *calendar year*.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• Routine screening tests and counseling for pregnant women and associated visits.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
Preventive Health Care Services that are in Addition to Those Required by the *Affordable Care Act*		
• Blood lead tests	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• Routine hearing examination limited to one exam per *member* per *calendar year*.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• Insulin on *our* Preventive Drug list for up to a 30-calendar day supply for one type of insulin per prescription or refill.	100% of *eligible charges* per 30-calendar day prescription or refill. *Deductible* does not apply.	Not covered.
• Other preventive drugs on *our* Preventive Drug list.	100% of *eligible charges* per 30-calendar day prescription or refill. *Deductible* does not apply.	Not covered.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Any *health care services* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in the *Preventive Health Care Services* section of this *contract*.
c. Routine eye examinations, except as otherwise covered under this *contract*.
d. Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
e. Tobacco cessation intervention programs and related *health care services*, except as otherwise covered under this *contract.*
f. Non-*preventive health care services* are not covered under this section of this *contract*.
g. Non-routine *health care services* are not covered under this section of this *contract*.
h. Non-prescribed over-the-counter medications.
i. Travel immunizations.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
S. *Reconstructive* Surgery	70% of *eligible charges* after the *deductible.*	Not covered.

We cover *medically necessary reconstructive* surgery due to *sickness*, accident or congenital anomaly. *Eligible charges* include eligible *hospital*, *physician*, laboratory, pathology, radiology and facility charges. Contact Customer Service to determine if a specific procedure is covered.

We also cover *reconstructive surgery following a mastectomy*. *Reconstructive surgery following a mastectomy* includes the following:

1. all stages of reconstruction of the breast on which the mastectomy has been performed if the mastectomy was determined to be *medically necessary* by the attending *physician*;
2. surgery and reconstruction of the other breast to produce symmetrical appearance;
3. prostheses; and
4. treatment of physical complications at all stages of mastectomy, including lymphedemas.

Services and supplies will be determined in consultation with the attending *physician* and patient. Such coverage will be subject to *coinsurance* and other plan provisions.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Health care services* to treat conditions that are *cosmetic* in nature.

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
T. *Skilled Nursing Facility* Care	Limited to the first 30 days per stay in a *skilled nursing facility.* *You* must be admitted to the *skilled nursing facility* within 24 hours after discharge from a *hospital* or surgical center or directly from emergency room care, urgent care facility or an *attending health care practitioner's* office and *you* must be admitted to the *skilled nursing facility* for continued treatment of the same *sickness* or *injury.*	
Skilled rehabilitation, including room and board.	70% of *eligible charges* after the *deductible.*	Not covered.
Daily *skilled care* as an alternative to *hospital confinements.*	70% of *eligible charges* after the *deductible.*	Not covered.

We cover the eligible *skilled nursing facility* services for post-acute treatment and *rehabilitative care* for *sickness* or *injury*. These services must be certified as *medically necessary* by an *attending health care professional* every seven days. Prior authorization by *us* or *our* designee is recommended for all *skilled nursing facility* stays.

Skilled nursing facility services include room and board, daily skilled nursing and related ancillary services.

We cover a semi-private room unless a *physician* recommends that a private room is *medically necessary* and so orders. *We* or *our* designee determine if a private room is *medically necessary.* In the event a *member* chooses to receive care in a private room under circumstances in which it is not *medically necessary, our* payment toward the cost of the room shall be based on the average semi-private room rate in that facility.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Skilled nursing facility care received from a *non-participating provider.*
c. Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
d. Respite or *custodial care.*
e. *Skilled nursing facility* care if *health care services* can be provided at a lower level of care (e.g. home care or care in an outpatient setting).
f. Care that is available to *you* at no cost to *you* or care provided under a government health care program (other than a program provided under Wis. Stat. Chapter 49).

Benefit	*Participating Provider Benefit, we* pay*:*	*Non-Participating Provider Benefit*
U. Vision Care – Pediatric		
• Exam (one per *calendar year*).	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• *Medically necessary* polycarbonate lenses with scratch coating (one pair per *calendar year*). • Frames from a selection of covered frames, one pair per *calendar year*. • Conventional contact lenses to correct visual acuity limitations, in lieu of all other *medically necessary* eyeglass frames and/or lenses. Coverage is limited to one pair of conventional contact lenses per *calendar year* or one 12-month series of planned replacement lenses per *calendar year*. Notwithstanding any other provisions of the *contract*, contact lenses for children under age 19 are covered whenever *medically necessary*.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• *Medically necessary* low vision services. • *Medically necessary* optional lenses and treatments.	70% of *eligible charges* after the *deductible*.	Not covered.

We cover *medically necessary* vision services and materials described above for, or related to, routine eye exams, lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, through the end of the month in which the *member* reaches age 19. Payment is limited to the most cost effective and *medically necessary* alternative. When *you* purchase lenses or optical devices that are more expensive than what is considered *medically necessary* by *us* or *our* designee, *you* will be responsible for the difference in purchase and maintenance cost**.** For information regarding whether any optical device or professional service is *medically necessary*, please call Customer Service.

Frames are limited to one frame per *calendar year* and must be chosen from a selection of covered frames. *Your provider* will show *you* which frames are covered by this *contract.*

We also cover *preventive health care services*, including routine screening to detect amblyopia or its risk factors in children ages 3-5. These services will be covered as shown in the *Preventive Health Care Services* section of this *contract* and not this section of the *contract*.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Vision care received from a *non-participating provider*.
c. Vision care received after the end of the month in which the *member* reaches age 19.
d. Lenses, frames or optical devices that *we* determine are not *medically necessary*.
e. *Health care services* or materials not meeting the standards of accepted optometric practices.
f. Repairs to frames and lenses.
g. Vision therapy.
h. Frames that are brand name or mid to high-end fashion frames.
i. Replacement of stolen or lost eyewear.

j. Non-prescription lenses, including reading glasses without a prescription.
k. Two pairs of eyeglasses in lieu of bifocals.
l. Elective lenses, including, but not limited to, toric, gas permeable and bifocal contact lenses.
m. Insurance of contact lenses
n. Saline or other solutions for the care of contact lenses.
o. Prosthetic devices and associated *health care services*.
p. Sunglasses.
q. Sport lenses and sport frames.
r. Special lens designs or coatings not *medically necessary*, including but not limited to special lenses or lens modifications that are not to correct visual acuity problems, tinted lenses, transition lenses, high-index lenses, progressive or invisible lenses, ultraviolet coating, and photochromic and non-reflective coating.
s. Replacement of lenses or frames due to *provider* error in prescribing, frame selection or measurement. The *provider* making the error is responsible for bearing the cost of correcting the error.

X. Exclusion List

In addition to any other exclusions or limitations specified in this *contract,* and with the exception of autism services which has a limited list of exclusions, *we* will not cover charges *incurred* for any of the following:

1. *Health care services* that *we* determine are not *medically necessary*.
2. *Health care services* that *we* determine are *investigative*, and associated expenses.
3. Charges for *health care services* determined to be duplicate services by *us*.
4. Personal comfort or convenience items.
5. Procedures that are *cosmetic*, or for convenience or comfort reasons, including preoperative procedures and any medical or surgical complications arising therefrom.
6. The following procedures and any related *health care services*: injection of filling material (collagen) other than for incontinence; salabrasion; rhytidectomy (face lift); dermabrasion; chemical peel; suction-assisted lipectomy (liposuction); hair removal; mastoplexy; mammoplasty, including augmentation or reduction mammoplasty (except for reconstruction associated with a covered mastectomy); correction of inverted nipples; sclerotherapy or other treatment for varicose veins less than 3.5 millimeters in size (e.g. telangiectasias, spider veins, reticular veins); excision or elimination of hanging skin on any part of the body, including panniculectomy, abdominoplasty and brachioplasty); mastectomy for gynecomastia; botulinum toxin or similar products, unless *you* receive prior authorization; any modification to the body that does not affect its function; labioplasty; treatment of sialorrhea (drooling or excessive salivation); or *health care services*, including surgical services for the treatment of excessive sweating (hyperhidrosis).
7. *Oral surgery*, except for excision of tumors and cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
8. *Health care services* received before *your* coverage with *us* begins or after *your* coverage with *us* ends.
9. *Health care services* not directly related to *your* care.
10. *Health care services* a *provider* ordered or that are rendered by *providers* that are unlicensed or not certified by the appropriate state regulatory agency.
11. *Health care services* not rendered in the most cost-efficient setting or methodology appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate. *You* are encouraged to consult with *your provider* regarding the most cost-efficient setting or methodology appropriate for *your sickness* or *injury*.
12. Charges that exceed the *non-participating provider reimbursement value* for *health care services* received from *non-participating providers*, including *non-participating provider* pharmacies.
13. *Health care services* prohibited by law or regulation, or illegal under applicable laws.
14. Vision lenses, frames and eyeglasses, except as covered under this *contract*.
15. If *you* are over age 18, contact lenses and their related fittings, except when prescribed as *medically necessary* for the treatment of keratoconus.
16. Any *health care services* provided by a relative (i.e., a spouse, parent, brother, sister or child of the *subscriber* or of the *subscriber's* spouse) or anyone who customarily lives in the *subscriber's* household.
17. *Health care services* performed by certified surgical technicians, surgical technicians, or certified operating room technicians.
18. *Health care services* provided by massage therapists, doulas and personal trainers.
19. *Health care services* provided by *providers* who have not completed professional level education and licensure as determined by *us*.
20. *Health care services* for the treatment of sexual dysfunction.
21. Massage therapy, except when billed by a chiropractor, physical therapist or occupational therapist.
22. Preventive medical services and supplies not ordered by a *provider*, including, but not limited to, cholesterol testing, glucose testing and mammograms, unless specifically listed in the schedule of *Preventive Health Care Services* or provided by a *participating provider*.

23. Any charges or loss to which a contributing cause was the *member's* commission of or attempt to commit a felony or to which a contributing cause was the *member* being engaged in an illegal occupation. This exclusion does not apply to any *sickness* or *injury* that is a result of an act of domestic violence or results from a medical condition such as alcoholism.
24. Financial or legal counseling services.
25. Elective abortions, except in situations where the life of the mother would be endangered if the fetus was carried to full term.
26. Travel, transportation or living expenses.
27. Photodynamic therapy and laser therapy for the treatment of acne.
28. Homeopathic, holistic or naturopathic medicine, including dietary supplements.
29. Drugs and medical devices that are only approved for compassionate use by the United States Food & Drug Administration.
30. *Health care services* under this plan that are paid under Medicare Part B but only to the extent: (i) *you* are eligible to be covered under Medicare Part B; (ii) *you* and/or *we* are not subject to Medicare secondary rules; and (iii) such an exclusion is permitted by applicable state and federal law.
31. *Health care services* including facility charges performed in a *non-participating provider* free-standing birth center unattached to a *hospital* facility.
32. Costs associated with *clinical trials* that are not *routine patient costs.*
33. *Health care services* associated with non-*covered services*, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
34. *Health care services* and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise *medically necessary*, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for driving under the influence/driving while intoxicated, competency evaluations, and adoption studies.
35. *Health care services* provided in connection with any *sickness* or *injury* arising out of, or sustained in the course of any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance, This exclusion applies regardless of whether benefits under workers' compensation laws or any similar laws have been claimed, paid, waived or compromised.
36. *Health care services* furnished by the U.S. Veterans Administration, unless federal law designates the *contract* as the primary payor and the U.S. Veterans Administration as the secondary payor.
37. *Health care services* furnished by any federal or state agency or a local political subdivision when *you* are not liable for the costs in absence of insurance, unless such coverage under the *contract* is required by law.
38. Halfway houses, extended care facilities or comparable facilities, foster care, adult foster care, and family childcare.
39. Professional services associated with substance use disorder intervention. A substance use disorder intervention is a gathering of family and/or friends to encourage *you* to seek substance use disorder treatment.
40. Sterilization reversals.
41. Nutritional and food supplements.
42. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment for the treatment of behavioral health conditions.
43. Health care professional services for maternity labor and delivery in the home.
44. Health club memberships, except as covered under this *contract.*
45. Acupuncture.

46. Recreational, *educational*, or self-help therapy or items primarily *educational* in nature or for vocation, comfort, convenience or recreation. Recreation therapy is therapy provided solely for the purpose of recreation, including, but not limited to: a) physical therapy or occupational therapy to improve athletic ability, and b) braces or guards to prevent sports injuries.

47. Sexual dysfunction *prescription drugs*, unless otherwise covered in this *contract* or approved for other use by an authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case reports.

48. Any weight loss programs and related services and/or drugs, except as otherwise covered as *preventive health care services.*

49. Private duty nursing, except as covered under this *contract.*

50. Charges for *health care services*: (a) for which a charge would not have been made in the absence of health insurance; (b) for which *you* are not legally obligated to pay; and/or (c) from *providers* who waive any *copayment, coinsurance,* or *deductible* that *you* are required to pay under this *contract,* except as required under state or federal law.

51. Non-*emergency services* received outside the United States.

52. *Health care services* related to surrogate pregnancy for a person who is not a *member* under this *contract*.

53. *Health care services* for gender reassignment, except when *medically necessary.*

54. Photographs, except for the condition of multiple dysplastic syndrome.

55. Coverage for costs associated with the translation of medical records and claims to English.

56. Repair of pierced body part and surgical repair of bald spots or loss of hair.

57. Services for or related to adoption and childbirth classes.

58. Services or confinements ordered by a court or law enforcement officer that are not *medically necessary*. Services that are not considered *medically necessary* include, but are not limited to, the following: custody evaluations, parenting assessment and /or competency, education classes for Driving Under the Influence (DUI) / Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, and domestic violence programs.

59. Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer the therapy.

60. Services that do not involve direct patient contact such as delivery charges and recordkeeping.

61. Non-FDA approved use of medical marijuana, cannabis or tetrahydrocannabinol (THC).

62. Costs, charges, fees and other losses for non-*health care services.*

63. Services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescriptions; reporting normal medical test results; providing educational materials;' updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; or services that would similarly not be charged for in an onsite medical office visit; or telephone conversations, e-mails, or facsimile transmissions between licensed health care *providers*; or e-mails, or facsimile transmissions between a licensed health care *provider* and a patient.

64. *Biofeedback.*

65. Prolotherapy.

66. Platelet-rich plasma.

67. Coma stimulation/recovery programs.

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

69. Salivary Hormone Testing.

The following exclusions are repeated from the "Description of Benefits" section":

***For ease of reference, some exclusions may contain headings for categories of *health care services*. Please note that, except when applying exclusions to autism services, exclusions listed under any category of *health care services* shall apply to all *health care services*, regardless of the heading under which they are listed.**

70. Ambulance Services:
    a. See all exclusions.*
    b. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.

71. Autism Services:
    a. Acupuncture
    b. Animal-based therapy including hippotherapy
    c. Auditory integration training
    d. Chelation therapy
    e. Childcare fees
    f. Cranial sacral therapy
    g. Hyperbaric oxygen therapy
    h. *Custodial care* or *respite care*
    i. Special diets or supplements
    j. *Provider* travel expenses
    k. Therapy, treatment or services when provided to a *member* who is residing in a residential treatment center, inpatient treatment or day treatment facility
    l. Costs for the facility or location or for the use of a facility or location when *treatment*, therapy or services are provided outside of *your* home
    m. Claims that have been determined by us to be fraudulent
    n. Treatment provided by parents or legal guardians who are otherwise qualified *providers*, supervising *providers*, therapists, professionals or paraprofessionals for treatment provided to their own children.

72. Chiropractic Services:
    a. See all exclusions.*
    b. Routine *maintenance care*.
    c. Blood, urine or hair analysis.
    d. Performance of ultrasound, MRI, EMG, waveform and nuclear medicine diagnostic studies, or other enhanced imaging.
    e. Manipulation under anesthesia.

73. Dental Services:
    a. See all exclusions.*
    b. Dental services covered under *your* dental plan.
    c. Preventive dental procedures.
    d. *Health care services* or dental services for and related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts.
    e. Orthodontia and all associated expenses.
    f. *Health care services* or dental services for or related to *oral surgery* and anesthesia for the removal of impacted teeth, removal of a tooth root without the removal of the whole tooth and root canal therapy.
    g. *Health care services* or dental services for cracked or broken teeth that result from biting, chewing, disease or decay.
    h. Dental implants, except due to *injury*.
    i. Prescriptions written by a *dentist* unless in connection with dental procedures covered by *us*.
    j. *Health care services* or dental services related to periodontal disease.
    k. Occlusal adjustment or occlusal equilibration.
    l. Treatment of bruxism.
    m. Surgical extraction of impacted wisdom teeth, except as above for accidental injury to sound, natural teeth or when required for treatment of an underlying medical condition.

74. Durable Medical Equipment (DME), Services and Prosthetics:
    a. See all exclusions.*
    b. Any durable medical equipment or supplies not listed as eligible on *our* durable medical equipment list, or as determined by *us* or *our* designee.

c. Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
d. Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
e. Routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of a one-month rental billed every six months.
f. Replacement or repair of items when: 1) damaged or destroyed by misuse, abuse or carelessness; 2) lost; or 3) stolen.
g. Replacement of equipment unless *we* determine it is *medically necessary*.
h. Repair or replacement of durable medical equipment less than three years after original purchase, except for insulin pumps.
i. Repair or replacement of insulin pumps less than one year after original purchase.
j. Replacement of over-the-counter batteries.
k. Duplicate or similar items.
l. Devices and computers to assist in communication and speech, except for speech aid devices and tracheoesophageal voice devices as covered under this section of the *contract*.
m. Durable medical equipment that *we* determine to be for *your* comfort, personal hygiene, or convenience including, but not limited to, personal fitness equipment and self-help devices not medical in nature.
n. Continuous passive motion (CPM) devices and mechanical stretching devices.
o. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs and cryotherapy; and home automated external defibrillator (AED).
p. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
q. Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
r. Over-the-counter orthotics and appliances.
s. Orthopedic shoes and custom molded foot orthotics, unless *you* have diabetes or peripheral vascular disease.
t. Charges for sales tax, mailing and delivery.
u. Durable medical equipment necessary for the operation of equipment determined not to be eligible for coverage.
v. Durable medical equipment, orthotics and prosthetics necessary for activities beyond *activities of daily living.*
w. Durable medical equipment, orthotics and prosthetics that *we* determine to have special features that are not *medically necessary*.
x. Wigs, toupees, hairpieces, cranial prothesis, hair implants, hair transplants, hair weaving, or hair loss prevention treatments.
y. Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.
z. Blood pressure cuffs and monitors.
aa. Enuresis alarms.
bb. Trusses.
cc. Ultrasonic nebulizers.
dd. Oral appliances for snoring.

75. *Emergency Services*:
    a. See all exclusions.*
    b. Non-*emergency services* received in an emergency room.

76. *Hearing Aids*, *Implantable Hearing Devices* and Related Services:
    a. See all exclusions.*
    b. Hearing protection equipment.
    c. *Hearing aid* batteries and cords.

77. Home Health Services:
    a. See all exclusions.*
    b. Companion and home care services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
    c. *Health care services* and other services provided as a substitute for a primary caregiver in the home.
    d. *Health care services* and other services that can be performed by a non-medical person or self-administered.
    e. *Health care services* and other services provided in *your* home for convenience.

f. *Health care services* and other services provided in *your* home due to lack of transportation.
g. *Custodial care*, except *home health aide services* as covered in this section.
h. *Health care services* and other services at any site other than *your* home.
i. Recreational therapy.
j. Domiciliary Care, such as meals-on-wheels, health visiting, and home help, provided by a welfare agency for people in their homes.

78. Hospice Care:
    a. See all exclusions.*
    b. *Health care services* and other services provided by *your* family or a person who shares *your* legal residence.
    c. Respite or rest care, except as specifically described in this section.

79. *Hospital* Services:
    a. See all exclusions.*
    b. Travel, transportation, other than ambulance transportation, or living expenses.
    c. Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
    d. Non-emergency ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
    e. *Health care services* to treat conditions *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom.
    f. Orthoptics and surgery for refractive conditions correctable by contacts or glasses (i.e., Lasik surgery).
    g. *Health care services* for gender reassignment, except when *medically necessary*.
    h. Genetic testing and associated *health care services*, except as covered under this *contract*.
    i. Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
    j. Routine foot care, unless required due to diabetes or peripheral vascular disease.
    k. Autopsies.
    l. *Bariatric surgeries*, including preoperative procedures, initial procedures, surgical revisions and subsequent procedures.
    m. *Health care services* or items for personal convenience, such as television rental.
    n. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
    o. Nutritional counseling, except when provided:
        1) During a *confinement*; or
        2) As outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or
        3) In a *physician's* office, clinic system or *hospital* setting to a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
        4) As counseling that is treated as a *preventive health care service*.
    p. Marital counseling, relationship counseling, family counseling except as covered under this *contract*, or other similar counseling or training services.
    q. Services to hold or confine a *member* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
    r. Counseling, studies, *confinements*, *health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by *us* or *our* designee, except as covered under this *contract*.
    s. Cardiac rehabilitation beyond Phase II.
    t. Visits in excess of stated limits for cardiac, cognitive or pulmonary rehabilitation.

80. *Infertility* Services:
    a. See all exclusions.*
    b. Reversal of voluntary sterilization.
    c. Adoption costs.
    d. *Health care services* associated with expenses for *infertility*, including assisted reproductive technology, except for those services related to a covered medical condition.
    e. Direct attempts to achieve pregnancy or increase chances of pregnancy by any means.
    f. Any laparascopic procedure during which an ovum is manipulated or the purpose of *fertility treatment* even if the laparoscopic procedure includes other purposes.
    g. Gamete intrafallopian transfer (GIFT) procedures.

h. Zygote intrafallopian transfer (ZIFT) procedures.
i. Intracytoplasmic sperm injection (ICSI).
j. In-vitro fertilization.
k. *Health care services* related to surrogate pregnancy for a person who is not a *member* under this *contract.*
l. Artificially assisted technology, such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
m. Sperm, ova or embryo acquisition, retrieval or storage.
n. *Prescription drugs* for which the primary purpose is to preserve fertility.

81. Office Visits:
    a. See all exclusions.*
    b. Health education, except when:
        1) Provided during an office visit for non-*preventive health care services*; or
        2) It is counseling that is treated as a *preventive health care service*.
    c. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
    d. Nutritional counseling, except when provided:
        1) During a *confinement*; or
        2) As outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or
        3) In a *physician's* office, clinic system or *hospital* setting to a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
        4) As counseling that is treated as a *preventive health care service*.
    e. Marital counseling, relationship counseling, family counseling except as covered under this *contract*, or other similar counseling or training services.
    f. Professional sign language and foreign language interpreter services in a *provider's* office.
    g. Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or treated as a *preventive health care service.*
    h. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by *us* or *our* designee.
    i. Genetic testing and associated *health care services*, except as covered under this *contract*.
    j. Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
    k. Routine foot care, unless required due to diabetes or peripheral vascular disease.
    l. Vision therapy/Orthoptics.
    m. Counseling, studies, or services ordered by a court or law enforcement officer that are not determined to be *medically necessary*, except as covered under this *contract.*
    n. Nutritional and food supplements.

82. Organ and Bone Marrow *Transplant Services*:
    a. See all exclusions.*
    b. *Transplant services* received from a *provider* that is not a *designated transplant network provider*.
    c. *Health care services* related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are *investigative* for *your* diagnosis or condition.
    d. *Health care services*, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by *us* or *our* designee.
    e. *Health care services*, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.
    f. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
    g. Computer search for donors.
    h. Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
    i. Travel expenses related to a covered transplant.
    j. *Health care services* for or in connection with fetal tissue transplantation, except for non-*investigative* stem cell transplants.

k. Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of US Food and Drug Administration (FDA) approved ventricular assist devices and transplants of artificial or mechanical devices as a bridge to a transplant or destination therapy.

83. Outpatient Behavioral Health Services for Full-Time Students
    a. See all exclusions.*

84. Physical Therapy, Occupational Therapy and Speech Therapy:
    a. See all exclusions.*
    b. *Custodial care* or *maintenance care*.
    c. Therapy provided in *your* home for convenience.
    d. Therapy for conditions that are self-correcting.
    e. Voice training and voice therapy absent a medical condition.
    f. *Investigative* therapies.
    g. Group therapy for physical therapy, occupational therapy and speech therapy.
    h. *Investigative* therapies for the treatment of autism, such as secretin infusion therapies.
    i. *Health care services* for homeopathy and immunoaugmentive therapy.

85. *Prescription Drug* Services:
    a. See all exclusions.*
    b. *Prescription drugs* obtained from a pharmacy that is a *non-participating provider.*
    c. Replacement of a *prescription drug* due to loss, damage, or theft.
    d. Drugs available over-the-counter (OTC) , except prescribed OTC drugs that are required to be covered as *preventive health care services* under the *Affordable Care Act* as covered under the "Preventive Contraceptive Methods and Counseling for Women" or "*Preventive Health Care Services*" sections of this *contract*.
    e. *Prescription drugs* equivalent to or similar to OTC drugs, except as covered under this *contract.*
    f. OTC home testing products, except as covered under this *contract.*
    g. Drugs not approved by the FDA and drugs not approved by the FDA for a particular use, except off-label drugs used for the treatment of cancer or when *we*, at *our* sole discretion, determine to include the drug on its *formulary* or approve coverage of the drug for the particular use.
    h. Take home drugs when dispensed by a *physician.*
    i. Weight loss drugs.
    j. Prescriptions written by a *dentist* unless in connection with dental procedures covered under this *contract.*
    k. Drugs used for *cosmetic* purposes.
    l. Unit dose packaging
    m. *Prescription drugs* for which the primary purpose is to preserve *fertility*.
    n. Non-FDA approved route of administration (e.g. drug that is FDA approved for oral use but is being applied topically).
    o. *Prescription drugs* given or administered as part of a drug manufacturer's study.
    p. *Prescription drugs* if purchased by mail order through a program not administered by *our* pharmacy vendor.
    q. *Prescription drugs* for the treatment of sexual dysfunction.
    r. Off-label use of drugs determined to be *investigative.*
    s. Certain *combination drugs* and other drugs, regardless of *formulary* status will not be covered according to *our* pharmacy policy titled Cost Benefit Program. Contact Customer Service for a copy of this policy or a list of the affected drugs. This policy is subject to change.
    t. *Compounded drugs* that are being used for bio-identical hormone replacement therapy, except as otherwise covered under this *contract.*
    u. Oral, injectable and insertable contraceptives and contraceptive devices, except when covered for a medical condition or as a *preventive health care service* in the "Preventive Contraceptive Methods and Counseling for Women" section of this *contract.*
    v. Prescribed or non-prescribed vitamins or minerals, including over-the-counter, unless covered as *preventive health care services.*
    w. All medicinal foods, enteral feedings, supplemental feedings, nutritional and electrolyte supplements, and infant formula.
    x. *Specialty drugs* obtained at any pharmacy other than *our* designated specialty pharmacy, except limited distribution *specialty drugs* only available through the manufacturer's select specialty pharmacy and not available through *our* designated specialty pharmacy.

y. *Compounded drugs* obtained from any pharmacy other than *our* designated compounding pharmacy.
z. Non-*formulary* drugs, unless an exception is obtained from *us.*
aa. Any portion of a charge for a *prescription drug* which *you* are not required to pay or for which *you* receive reimbursement due to use of a manufacturer's coupon, rebate or other program that alters the amount *you* are legally obligated to pay, and/or waives any *coinsurance* or *deductible* that *you* are required to pay under this *contract*, except as required under state or federal law.

86. Preventive Contraceptive Methods and Counseling for Women:
    a. See all exclusions.*
    b. Contraceptives and related *health care services* received from *non-participating providers*.
    c. Sterilization procedures performed by *non-participating providers*.
    d. Abortions are not covered under this section of this *contract.*
    e. Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
    f. Hysterectomies are not covered under this section of this *contract*.
    g. Anesthesia and facility services related to sterilization procedures that are performed during other surgical procedures, including, but not limited to, Cesarean section birth, gall bladder removal, and abdominal hernia repair, are not covered under this section of this *contract.*
    h. Reversal of sterilization procedures.
    i. Non-*preventive health care services* are not covered under this section of this *contract.*

87. *Preventive Health Care Services*:
    a. See all exclusions.*
    b. Any *health care services* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in the *Preventive Health Care Services* section of this *contract.*
    c. Routine eye examinations, except as otherwise covered under this *contract*
    d. Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
    e. Tobacco cessation intervention programs and related *health care services*, except as otherwise covered under this *contract.*
    f. Non-*preventive health care services* are not covered under this section of this *contract.*
    g. Non-routine *health care services* are not covered under the "*Preventive Health Care Services*" section of this *contract.*
    h. Non-prescribed over-the-counter medications.
    i. Travel immunizations.

88. *Reconstructive* Surgery:
    a. See all exclusions.*
    b. *Health care services* to treat conditions that are *cosmetic* in nature.

89. *Skilled Nursing Facility* Care:
    a. See all exclusions.*
    b. Skilled nursing facility care received from a *non-participating provider.*
    c. Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
    d. Respite or *custodial care*.
    e. *Skilled nursing facility* care if *health care services* can be provided at a lower level of care (e.g. home care or care in an outpatient setting).
    f. Care that is available to *you* at no cost to *you* or care provided under a government health care program (other than a program provided under Wis. Stat. Chapter 49).

90. Vision Care – Pediatric:
    a. See all exclusions.*
    b. Vision care received from a *non-participating provider.*
    c. Vision care received after the end of the month in which the *member* reaches age 19.
    d. Lenses, frames or optical devices not *medically necessary*.
    e. *Health care services* or materials not meeting the standards of accepted optometric practices.
    f. Repairs to frames and lenses.
    g. Vision therapy.
    h. Frames that are brand name or mid to high-end fashion frames.
    i. Replacement of stolen or lost eyewear.
    j. Non-prescription lenses, including reading glasses without a prescription.
    k. Two pairs of eyeglasses in lieu of bifocals.
    l. Elective lenses, including, but not limited to, toric, gas permeable and bifocal contact lenses.

m. Insurance of contact lenses
n. Saline or other solutions for the care of contact lenses.
o. Prosthetic devices and associated *health care services*.
p. Sunglasses.
q. Sport lenses and sport frames.
r. Special lens designs or coatings not *medically necessary*, including, but not limited to, special lenses or lens modifications that are not to correct visual acuity problems, tinted lenses, transition lenses, high-index lenses, progressive or invisible lenses, ultraviolet coating, and photochromic and non-reflective coating.
s. Replacement of lenses or frames due to *provider* error in prescribing, frame selection or measurement. The *provider* making the error is responsible for bearing the cost of correcting the error.

XI. Ending *Your* Coverage

Your coverage under this *contract* will end on the earliest of the following dates:

1. The date *we* discontinue or do not renew this *contract* as provided herein.
2. The end of the month in which *we* receive *your* written request to cancel coverage, unless a later date is requested.
3. The end of the month in which *you* ceased to be eligible for coverage under this *contract.*
4. The end of the month in which the *subscriber's* covered spouse or covered *dependent* is no longer eligible as a covered spouse or covered *dependent*.
5. For a *subscriber's* spouse who is a *covered person*, the date the *subscriber's* spouse is no longer married to the *subscriber* due to divorce or annulment.
6. For a child of a covered dependent child (i.e. the *subscriber's* grandchild), the date the *subscriber's* child reaches age 18.
7. For a *full-time student returning from military duty*, the end of the month in which full-time student status ceases.
8. In accordance with the terms of the applicable grace period, if *premium* has not been paid.
9. The date *you* (or someone acting on *your* behalf) performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of this *contract*, according to the notice *we* provide when *we* rescind or terminate this *contract.*
10. The end of the month following the date *you* enter active military duty of more than 31 calendar days. Upon completion of active military duty, *your* coverage will be reinstated, provided *you* notify *us* within 90 calendar days after the end of *your* active duty.
11. The end of the month or such later date, as determined by *us*, after the *subscriber* moves outside our *geographical service area*.

XII. Portability of Coverage

If a *dependent* loses coverage under this *contract* due to death of the *subscriber*, loss of eligibility under the *contract* as a *dependent* including the *subscriber's* enrollment in Medicare or divorce in the case of a spouse or a *dependent*, *we* will allow the covered *dependents* of the *subscriber* to remain covered under this *contract* as long as a covered spouse becomes the *subscriber* to the *contract* or, if there is no covered spouse, each dependent child may transfer as a *subscriber* to another substantially similar *contract* offered by *us*. *Dependents* under age 18 may become *subscribers* only if they receive parental or guardian consent. *We* will permit the transfer (if election is made within 31 calendar days of the date of loss of coverage) without any limitation or other restriction of any type other than those which applied to the *subscriber* under the prior contract.

If *you* transfer to a substantially similar contract offered by *us*, any amounts that *you* already paid under this *contract* for *covered services* that are subject to *coinsurance*, *deductibles* and *out of pocket limits*, or any *covered services* that *you* received that are subject to benefit limits or visit maximums under this *contract*, will continue to count toward any applicable *deductibles, out of pocket limits*, benefit limits and/or visit maximums.

XIII. Subrogation and Reimbursement

Our Subrogation Rights

For the purposes of this section, "subrogation" means *our* right to allocate risk so that *your* medical claims are ultimately paid by the party that should rightfully bear the burden of the loss.

1. *We* are subrogated to any and all claims and causes of action that might arise against any person, corporation, and/or other entity and any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision, liability insurance policies, homeowners liability insurance coverage, medical malpractice insurance coverage, patient compensation fund, and any applicable umbrella insurance coverage or other insurance or funds; and
2. *Our* subrogation interest is the reasonable cash value of any benefits received by *you*. *Our* subrogation interest applies only after *you* have received a full recovery for *your sickness* or *injury* from another source of compensation for *your sickness* or *injury;* and
3. *Our* right to recover *our* subrogation interest is subject to a pro rata subtraction for actual monies paid for costs and reasonable attorney fees *you* pay in obtaining *your* recovery unless *we* are separately represented by an attorney; and
4. If *we* are separately represented by an attorney, the attorney representing *us* and the attorney representing the covered person may enter into an agreement regarding allocation of costs and reasonable attorney fees. If *we* and the covered person cannot reach agreement on allocation, *we* and the covered person shall submit the matter to binding arbitration; and
5. Nothing in this section shall limit *our* right to recovery from another source which might otherwise exist at law.

Notice Requirement

You must provide timely written notice to *us* of the pending claim, if *you* make a claim against a third party for damages that include repayment for medical and medically related expenses *incurred* for *your* benefit. Notwithstanding any other law to the contrary, the statute of limitations applicable to *our* rights for reimbursement or subrogation does not commence to run until the notice has been given.

XIV. Coordination of Benefits

As a *member*, *you* agree to permit *us* to coordinate *our* obligations under this *contract* with payments under any other health benefit plans as specified below, which cover *you* as a *subscriber* or *dependent*. *You* also agree to provide any information or submit any claims to other health benefit plans necessary for this purpose. *You* agree to authorize *our* billing to other health plans, for purposes of coordination of benefits.

Unless applicable law prevents disclosure of the information without the consent of *you* or *your* representative, *you* must provide any facts needed to pay the claim. If the information cannot be disclosed without consent, *we* will not pay benefits until the information is given.

Application. This Coordination of Benefits provision applies when *you* have health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan might cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Definitions. These definitions only apply to the Coordination of Benefits provision.

Allowable Expenses. Means health care services or expenses, including *copayments*, *deductibles* and *coinsurance* that are covered at least in part by any of the plans covering *you*. When a plan provides benefits in the form of services (for example a staff model HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.

Claim Determination Period. Means a *calendar year*. However, it does not include any part of a year during which *you* have no coverage under this *contract*, or before the date this Coordination of Benefit provision or a similar provision takes effect.

Closed Panel Plan. Means a plan that provides health benefits to persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the plan and that limits or excludes benefits or services provided by other *providers*, except in cases of emergency or referral by a panel member.

Custodial Parent. Means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the *calendar year* without regard to any temporary visitation.

Plan. Means any of the following that provides benefits or services for medical or dental care or treatment.

1. Group, blanket, franchise, closed panel or other forms of group or group type coverage (insured or uninsured).
2. Hospital indemnity benefits in excess of $200 per day.
3. Medical care components of group long-term care policies, such as skilled nursing care.
4. A labor-management trusteed plan or a union welfare plan.
5. An employer or multi-employer plan or employee benefit plan.
6. Medicare or other governmental benefits, as permitted by law.
7. Insurance required or provided by statute.
8. Medical benefits under group or individual automobile policies.
9. Individual or family insurance for hospital or medical treatment or expenses.
10. Closed panel or other individual coverage for hospital or medical treatment or expenses.

Plan does not include any:

1. Amounts of hospital indemnity insurance of $200 or less per day.
2. Benefits for non-medical components of group long-term care policies.
3. School accident type coverages.
4. Medicare supplement policies.
5. Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage listed above is a separate plan. If a plan has two parts and Coordination of Benefits rules apply to one of the two, each of the parts is treated as a separate plan. The benefits provided by a plan include those that would have been provided if a claim had been duly made.

Primary Plan/Secondary Plan. Means the order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan," when compared to the other plan covering *you*.

When this *contract* is the primary plan, its benefits are determined before those of any other plan and without considering any other plan*'s* benefits. When this *contract* is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan*'s* benefits.

Order of Benefit Determination Rules. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

This plan determines its order of benefits by using the first of the following that applies:

1. **Nondependent/Dependent:** The plan that covers the person other than as a dependent, for example as an employee, *subscriber*, or retiree, is the primary plan; and the plan that covers the person as a dependent is the secondary plan.

   Exception: If the person is a Medicare beneficiary and federal law makes Medicare:

   a. secondary to the plan covering the person as a *dependent*; and
   b. primary to the plan covering the person as a nondependent (e.g., a retired employee);

   then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary.

2. **Child Covered Under More Than One Plan:** The order of benefits when a child is covered by more than one plan is:

   a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.

   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the custodial parent;
      - The plan of the non-custodial parent; and then
      - The plan of the spouse of the non-custodial parent.

   d. For a child covered under more than one plan by persons who are not the parents of such child, the order of benefits shall be determined under paragraph 2.a. of this section as if those persons were parents of such child.

   e. For a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the rule in paragraph 5 of this section applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in paragraph 2.a of this section to the dependent child's parent(s) and the dependent child's spouse.

3. **Active/Inactive Employee:** The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the 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; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits. For example, coverage provided to a person as a retired worker and as a dependent of an actively working spouse will be determined under the rule in paragraph 1.

4. **Continuation Coverage:** If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:

   a. The plan covering the person as an employee, *member*, *subscriber*, or retiree (or as a *dependent* of an employee, *member, subscriber*, or retiree) is the primary plan; and
   b. The continuation coverage is the secondary plan.

   If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits.

5. **Longer/Shorter Length of Coverage.** The plan that covered *you* as an employee, *member, subscriber* or retiree longer is primary.

   Note: Under this *contract, we* will not pay more than *we* would pay as the primary plan.

The Effect of the Benefits of this Plan*:* When this plan is secondary, it may reduce its benefits at the time of processing, so that the total benefits paid or provided by all plans for each claim are not more than 100% of total allowable expenses for such claim. The reduction in this plan's benefits is equal to the difference between:

1. The benefit payments that this plan would have paid had it been the primary plan; and

2. The benefit payments that this plan actually paid or provided.

When the benefits of this plan are reduced as described above, each *benefit* is reduced in proportion to any applicable limit, such as the *deductible* of this plan.

Right to Receive and Release Information. Certain facts about health care coverage and services are needed to apply Coordination of Benefit rules and to determine benefits payable under this plan and other plans. *We* may get the facts from or give them to any other organization or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. *We* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give *us* any facts *we* need to apply those rules and determine benefits payable. Release of information will comply with state and federal laws.

Facility of Payment. A payment made under another plan may have included an amount that should have been paid under this plan. If it does, *we* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this plan. *We* will not pay that amount again. The term "payment made" includes providing benefits in the form of services. In this case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by *us* is more than it should have paid, *we* may recover the excess from one or more of the following:

1. The persons *we* have paid or for whom *we* have paid; or

2. Any other person or organization that may be responsible for the benefits or services provided to *you*.

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

Coordinating with Medicare: This section describes the method of payment if Medicare pays as the primary plan.

If a *provider* has accepted assignment of Medicare, *we* determine allowable expenses based upon the amount allowed by Medicare. *Our* allowable expenses are the lesser of (1) the *fee schedule* amount; (2) the *non-participating provider reimbursement value,* as applicable; or (3) the Medicare allowable amount. *We* pay the difference between what Medicare pays and *our* allowable expenses.

Renal Failure. If *you* begin to have services related to renal failure, *we* request that *you* sign up for Medicare.

XV. How to Submit a Claim if *You* Receive a Bill for *Covered Services* from a *Provider*

Claim Forms. If *you* submit a notice of claim to *us* without adequate written proof of loss, *we* will furnish *you* a claim form for filing *your* proof of loss. If *you* are not furnished a claim form within 15 calendar days after *you* provided notice of a claim to *us*, *you* should submit written proof which documents the date of service, the type of service, a specific medical diagnosis and treatment, service or procedure code, *provider* name and itemized charges for which the claim is made.

Timely Payment of Claims. *Post-service claims* for benefits will be paid promptly upon receipt of an itemized bill and written proof of loss. All or any portion of any benefits provided by *us* may be paid directly to the *provider* rendering the services. Payment will be made according to *our* coverage guidelines.

Payment of Claims. All or any portion of any benefits provided to *you* or on *your* behalf for *hospital*, nursing, medical or surgical services may, at *our* option, be paid directly to the *hospital* or *provider* providing such services.

At *our* option, all payments for claims may be made directly to the *provider* of medical services, the custodial parent or Wisconsin Department of Human Services rather than to the *subscriber*, for claims *incurred* by a child who is covered as a *dependent* of a *subscriber* who has legal responsibility for the *dependent's* medical care pursuant to a court order, provided *we* are informed of such order. This payment will discharge *us* from all further liability to the extent of the payment made. If the *member* who receives such services is deceased at the time of payment, *we* may at *our* option pay the *provider* of medical services or the *member's* estate.

Bills from *Participating Providers*

When *you* present *your* identification card at the time of requesting services from *participating providers*, paperwork and submission of *post-service claims* relating to services will be handled for *you* by *your participating provider*. *You* may be asked by *your provider* to sign a form allowing *your provider* to submit claims on *your* behalf. If *you* receive an invoice or bill from *your provider* for services before it has been submitted to *us*, simply return the bill or invoice to *your provider*, noting *your* enrollment with *us*. *Your provider* will then submit the *post-service claim* to *us* in accordance with the terms of its participation agreement. *Your post-service claim* will be processed for payment according to *our* guidelines. *We* must receive *post-service claims* within 90 days after the date services were *incurred*

Proof of Loss and Claim Submission. If *you* are directly submitting an itemized bill and written proof of loss to *us*, *you* must submit *your* itemized bill and written proof of loss within 90 calendar days after the date the service was *incurred*. The itemized bill and written proof of loss must document the date of service, the type of service, a specific medical diagnosis and treatment, service or procedure code, *provider* name and itemized charges.

If *you* or *your provider* do not file the required information within 90 days after receiving a *health care service*, benefits will be paid for *covered services* 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, but 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 *contract*.

Bills from *Non-Participating Providers*

Proof of Loss and Claim Submission. *You* must submit *your* itemized bill and written proof of loss to *us* within 90 calendar days after the date the service was *incurred*. The itemized bill and written proof of loss must document the date of service, the type of service, a specific medical diagnosis and treatment, service or procedure code, *provider* name and itemized charges.

If *you* do not file the required information within 90 days after receiving a *health care service*, benefits will be paid for *covered services* 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, but 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 *contract*.

XVI. Initial Benefit Determinations of *Post-Service Claims*

Post-service claims are claims that are filed for payment of benefits by *us* after medical care has been received and are submitted in accordance with *our post-service claim* filing procedures.

If *your* attending *provider* submits a *post-service claim* on *your* behalf, the *provider* will be treated as *your* authorized representative by *us* for purposes of such claim and associated appeals unless *you* specifically direct otherwise to *us* within ten business days from the date of *our* notification to *you* that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

Post-Service Claims. *We* will notify *you* of our decision on *your* claim as soon as possible, but not later than 30 days after *our* receipt of a *post-service claim*.

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

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

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* medical condition requires a shorter time frame. *You* or a *provider* 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 *provider* with knowledge of *your* medical 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.

Claim Decisions

If benefits are payable on charges for services covered under this *contract*, *we* will pay such benefits directly to the *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 in this *contract*. 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 *contract* 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 *investigative*, the denial notice will include an explanation of the scientific or clinical judgment for the determination applying the terms of this *contract* 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.

XVII. Initial Benefit Determinations of *Pre-Service Claims* and Concurrent Review

Pre-Service Claims. If *your pre-service claim* involves i*nvestigative* 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.*

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

A request to extend a prior authorization of treatment that involves an *urgent claim* 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.

XVIII. Internal *Grievance* and Appeals Procedures

General *Grievance* Information

Situations might occasionally arise when *you* question or are unhappy with *our* claim 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 and the inside cover of this *contract.* 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.

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:

Aspirus Health Plan, Inc.
Attention: Grievance Coordinator
P.O. Box 1062
Minneapolis, MN 55440
Fax: 763.847.4400

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.

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

Any *grievance* filed by *your provider* regarding a *prescription 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 drug*, durable medical equipment or medical device that is not covered under this *contract*.

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 and the inside of this *contract*.

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 this *contract*. 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 rules of evidence are followed. Also, cross-examination of the Committee's members, its advisors, or *our* 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:

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.*

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.*

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.

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.*

Expedited *Grievance* Procedure

To file an *expedited grievance*, *you* or *your provider* 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:

Aspirus Health Plan, Inc.
Attention: Grievance Coordinator
P.O. Box 1062
Minneapolis, MN 55440
1-866.631.4611 (toll-free)
Fax: 763.847.4400

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

Any *expedited grievance* filed by *your provider* regarding a *prescription 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 drug*, durable medical equipment or medical device that is not covered under this *contract.*

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 rules of evidence are followed.

Also, cross-examination of the Committee's members, its advisors, or *our* 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* medical 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 *contract* 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 *investigative*, then the denial notice will provide *you* with either an explanation of the scientific or clinical judgment for the determination applying the terms of this *contract* to *your* medical circumstances or a statement that such explanation will be provided, free of charge, upon *your* request.

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

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

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

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

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 *contract* 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 *investigative*, 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 *contract* 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.

XIX. External Review Process

You may be entitled to an independent external review by an Independent Review Organization (IRO) if *you* have received an *investigative* treatment determination, *adverse determination* or a *rescission* of coverage determination.

In general, *you* must complete all *grievance*/appeal options described above before requesting an independent external review. This includes waiting for *our* determination on *your grievance*/appeal. However, if *we* agree with *you* that the matter should proceed directly to independent review, or if *you* need immediate medical treatment and believe that the time period for resolving an internal *grievance* will cause a delay that could jeopardize *your* life or health, *you* may ask to bypass *our* internal *grievance* process. In these situations, *your* request will be processed on an expedited basis.

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

Aspirus Health Plan, Inc.
Attention: Grievance Coordinator
P.O. Box 1062
Minneapolis, MN 55440
Fax: 763.847.4400

Your request for an independent external review must include:

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

Within five days of *our* receipt of *your* request, an accredited IRO will be assigned to *your* case through an unbiased random selection process. The assigned IRO will send *you* a notice of acceptance within one business day of receipt, advising *you* of *your* right to submit additional information within ten business days of *your* receipt of the notice from the IRO. The assigned

IRO will also deliver a notice of the final external review decision in writing to *you* and *us* within 45 calendar days of their receipt of the request. Some of the information *you* provide to the IRO may be shared with appropriate regulatory authorities.

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

Unless *your* case involves the rescission of this *contract*, the IRO's decision is binding for both *you* and *us. You* are not responsible for costs associated with the independent external review.

How to File a Complaint with the Wisconsin Office of the Commissioner of Insurance

You may resolve *your* problem by taking the steps outlined in the sections of *your* contract entitled "Internal Grievance and Appeals Procedures" or "External Review Process".

You may also contact the Office of the Commissioner of Insurance**,** a state agency which enforces Wisconsin's insurance laws, and file a complaint.

You can file a complaint electronically with the Office of the Commissioner of Insurance at its website at http://oci.wi.gov/, or by writing to:

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

Or *you* can call 1.800.236.8517 outside of Madison or 266-0103 in Madison and request a complaint form.

XX. Definitions

Activities of Daily Living	*Eating*, *toileting*, *transferring*, *bathing*, *dressing*, walking, and *continence*.
Acute Care Facility	A facility that provides care to *you* when *you* are in the acute phase of a *sickness* or *injury* and will probably have a stay of less than 30 calendar days.
Adverse Determination	A determination by *us* to which all of the following apply: 1. *We* have reviewed admission to a health care facility, the availability of care, the continued stay or other treatment; 2. Based on the information provided, the treatment does not meet *our* requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness; and 3. Based on the information provided, *we* reduced, denied or terminated the treatment or payment of the *treatment*. An *adverse determination* also includes the denial of a prior authorization request for *health care services* from a *non-participating provider*. The right to an independent external review applies only when *you* feel the *non-participating provider's* clinical expertise is *medically necessary* and the expertise is not available from a *participating provider*.
Affordable Care Act	The federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance and regulations issued under these acts.
Attending Health Care Professional	The health care professional providing care within the scope of the professional's practice and with primary responsibility for the care provided to *you*. *Attending health care professional* shall include only *physicians*; chiropractors; *dentists*; mental health professionals; podiatrists; and advanced practice nurses.
Bariatric Surgery	Surgery and related expenses for the treatment of obesity.
Bathing	Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
Biofeedback	The technique of making unconscious or involuntary bodily processes (such as heartbeat or brain waves) perceptible to the senses in order to manipulate them by conscious mental control.
Bone Anchored Hearing Aid	A surgically implantable system for treatment of hearing loss that works through direct bone conduction.
Calendar Year	The 12-month period beginning January 1 and ending the following December 31.

Clinical Trial

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, surgical musculoskeletal disorders of the spine, hip or knees, cardiovascular disease or other disease or condition or other diseases or disorders for which, as *we* determine, a *clinical trial* meets the qualifying *clinical trial* criterial stated below.

The *clinical trial* must meet one of the following:

1. Federally-funded *clinical trial* in which 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.
   b. Centers for Disease Control and Prevention.
   c. Agency for Health Care Research and Quality.
   d. Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in paragraphs a. through d. above or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. If the clinical study or investigation is conducted by the Department of Veterans Affairs, Department of Defense, or the Department of Energy, has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and there has been an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. A study or investigation conducted under an investigational new drug application reviewed by the FDA.
3. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Cochlear Implant

An implantable instrument or device that is designed to enhance hearing.

Coinsurance

A portion of *eligible charges* that is paid by *you* and a separate portion that is paid by *us* for *covered services* and supplies. *Your coinsurance* is a percentage of those *eligible charges* that are the 1) discounted charges that are negotiated with the *participating provider* and calculated at the time the claim is processed; or 2) the *non-participating provider reimbursement value*.

Combination Drugs

A *prescription drug* in which two or more chemical entities are combined into one commercially available dosage form.

Compounded Drugs

Customized medications prepared by a pharmacist from scratch using raw chemicals, powders and devices according to a *physician's* specifications to meet *your* needs.

Concurrent Care Decision

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

Confinement

An uninterrupted stay of 24 hours or more in a *hospital*, *skilled nursing facility*, rehabilitation facility, or licensed residential treatment facility.

Continence

Ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

Contract

The legal agreement between the *subscriber* and *us* relating to the provision of *health care services*, which consists of this document and any amendments.

Convenience Care Center	A health care clinic whose primary purpose is to provide immediate treatment for the diagnosis of minor conditions.
Copayment	The fixed amount of *eligible charges you* must pay to the *provider* for covered *health care services* received. The *copayment* may not exceed the charge billed for the covered *health care services*.
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 this *contract*, including but not limited to, medical records and reports.
Cosmetic	Services and procedures that improve physical appearance but do not correct or improve a physiological function and are not *medically necessary*.
Covered Services	Services or supplies that are provided by *your* licensed *provider* or clinic and covered by *us*, subject to all of the terms, conditions, limitations and exclusions of the *contract*.
Custodial Care	Services to assist in *activities of daily living* and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, *bathing*, and *eating*.
Day Treatment Services	Any professional or *health care services* at a *hospital* or licensed treatment facility for the treatment of mental and substance use disorders.
Deductible	The amount of *eligible charges* that *you* must *incur* and pay in a *calendar year* before *we* will pay benefits.
Dental Specialist	A *dentist* board eligible or certified in the areas of endodontics, *oral surgery*, orthodontics, pedodontics, periodontics, and prosthodontics.
Dentist	A licensed doctor of dental surgery or dental medicine, lawfully performing dental services in accordance with governmental licensing privileges and limitations.
Dependent(s)	The *subscriber's* spouse or children as described in the "Eligibility, Enrollment, and *Effective Date*" section.
Designated Transplant Network Provider	Any licensed *hospital*, health care *provider*, group or association of health care *providers* that satisfies the quality, outcome, and accessibility needs of *us* and *our members*, and has contracted to participate as a designated transplant *provider* in the specific *participating provider* network designated by *us* to provide benefits for organ or bone marrow transplant or stem cell support and all related services and aftercare for *you*.
Dressing	Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
Eating	Feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.
Educational	A service or supply: (1) that is primarily intended to provide training in the *activities of daily living*, instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or (2) that is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental, or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending *physician.*
Effective Date	The date *you* become eligible for health care benefits under this *contract* and complete all enrollment requirements.
Eligible Charges	A charge for *health care services*, subject to all of the terms, conditions, limitations and exclusions of the *contract* and for which *we* or *you* will pay.
Eligible Individual	An individual whom *we* determine has met the eligibility requirements for enrolling in this *contract*, which requirements include, but are not limited to, residency in *our geographical service area*. Such residency requirement does not apply to *dependents.*

Emergency

The onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:

1. Placing *your* health (or, if *you* are a pregnant individual, the health of *you* or *your* unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services

A medical screening examination that is within the capability of the emergency department of a *hospital*, including ancillary services routinely available to the emergency department, to evaluate such *emergency* medical condition and such further medical examination and treatment required to stabilize the patient.

Essential Health Benefits

The categories of *covered services* this *contract* is required to cover under the *Affordable Care Act*.

Expedited Grievance

A *grievance* to which any of the following conditions apply:

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

Fee-for-Service

Method of payment for *provider* services based on each visit or service rendered.

Fee Schedule

The amount that the *participating provider* has contractually agreed to accept as reimbursement in full for *covered services* and supplies. This contracted amount may be less than the *provider's* usual charge for the service.

If *health care services* are delivered to *you* via telemedicine by a distant site *participating provider* who is **not** a designated *participating provider* for *web based (online) care*, *we* will reimburse such *participating provider* on the same basis and using the same *fee schedule* as would apply if the *covered services* had been delivered in person by the distant site *participating provider*.

Formulary

A list, which may change from time to time, of *prescription drugs* which *we*, in *our* sole discretion have established for use with this *contract*.

Full-Time Student Returning from Military Duty

A child of a *subscriber* who meets all of the following criteria:

1. The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education;
2. The child was under the age of 27 when called to federal active duty;
3. Within 12 months after returning from federal active duty, the child returned to an institution of higher education on a full-time basis, regardless of age; and
4. The child must: (1) attend an accredited school for the number of credits, hours, or courses required by the school to be considered a full-time student; (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his/her degree. The child continues to be a full-time student during periods of vacation or between term periods established by the school.

Geographical Service Area

The region in which *we* operate and *your contract* is available, as determined by *us*. Please see www.aspirushealthplan.com for more information.

Grievance	Any dissatisfaction with *us* or *our* administration of *your contract* that *you* express to *us* in writing. For example, *you* might file a *grievance* about *our* provision of services, *our* determination to reform or rescind a policy, *our* determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders, or *our* claims practices.
Habilitative Therapy	Therapy provided to develop initial functional levels of movement, strength, daily activity, or speech.
Health Care Services	Medical or behavioral services including pharmaceuticals, devices, technologies, tests, treatments, therapies, supplies, procedures, hospitalizations, or *provider* visits.
Health Insurance Marketplace	A resource established and operated by the state or the U.S. Department of Health and Human Services where qualified consumers can learn about and purchase *qualified health plans.*
Health Plan	Health insurance coverage offered in the individual market or a small group health plan offered in the small group market, that provides *essential health benefits*, all within the meaning of the *Affordable Care Act*. A health plan does not include coverage that is excepted benefits under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
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.
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 professional*; (2) the plan is approved by *your attending health care professional* in writing; (3) the plan is reviewed by *your attending health care professional* every two months (or less frequently if *your provider* believes and *we* agree that less frequent reviews are enough); and (4) *home care* is provided or coordinated by a home health agency or certified rehabilitation agency that is licensed by the Wisconsin Department of Health Services or certified by Medicare.
Home Health Aide Services	Services performed by a home health aide which: (1) are not required to be performed by a registered nurse or licensed practical nurse; and (2) primarily aid the patient in performing normal *activities of daily living*, which may include *custodial care.*
Homebound	When *you* are unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute homebound status.
Hospital	A facility that provides diagnostic, medical, therapeutic, and surgical services by or under the direction of *physicians* and with 24-hour registered nursing services. The *hospital* is not mainly a place for rest or *custodial care* and is not a nursing home or similar facility.
Implantable Hearing Device	Any implantable instrument or device that is designed to enhance hearing, including *cochlear implants* and *bone anchored hearing aids*.
Incomplete Claim	A *correctly filed claim* that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, and subrogation questionnaire.
Incorrectly Filed Claim	A claim that is filed but lacks information which enables *us* to determine what, if any, benefits are payable under the terms and conditions of this *contract*. Examples include, but are not limited to, claims missing procedure codes, diagnosis or dates of service.
Incurred	Services and supplies rendered to a *member* are considered to be "*incurred*" at the time or date the service or supply was actually purchased or provided.

Infertility

Inability or diminished ability to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

1. One year, if *you* are a female under age 35 or a male of any age, or
2. Six months, if *you* are a female age 35 or older,

provided that *your infertility* is not related to voluntary sterilization or failed reversal of voluntary sterilization; or

Inability or diminished ability to produce offspring, including but not limited to a woman's repeated failure 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 *your provider.*

Infertility Treatment/ Fertility Treatment

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

1. *Fertility* tests and *prescription drugs.*
2. Tests and exams done to prepare for or follow through with induced conception.
3. Surgical reversal of a sterilized state that was a result of a previous surgery.
4. Sperm enhancement procedures.
5. Direct attempts to cause or maintain pregnancy by any means including, but nmot limited to: Hormone therapy or *prescription drugs*; artificial insemination; in vitro insemination; GIFT or ZIFT; embryo transfer; and freezing and/or storage of embryo, eggs, or semen.

Injury

Bodily damage other than *sickness,* including all related conditions and recurrent symptoms.

Investigative

As determined by *us,* a drug, device or medical treatment or procedure is *investigative* if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. *We* will consider the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the FDA; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether an oncology treatment is included in the applicable National Comprehensive Cancer Network (NCCN) guideline, as appropriate for its proposed use, or whether a drug is included in any authoritative compendia as identified by the Medicare program such as, the National Comprehensive Cancer Network Drugs and Biologics Compendium, as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care *providers* in the applicable specialty as determined by a sampling of *providers,* including whether there are protocols used by the treating facility or another facility, studying the same drug, device, medical treatment or procedure.

Maintenance Care

Care that is not *habilitative* or *rehabilitative therapy* and there is lack of documented significant progress in functional status over a reasonable period of time.

Medical Literature

Articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally accepted scientific standards and must not use case reports to satisfy this criterion.

Medically Necessary

Any *health care services*, *preventive health care services*, and other preventive services that *we*, in *our* discretion and on a case by case basis, determine are appropriate and necessary in terms of type, frequency, level, setting, and duration, for the diagnosis or condition; and the care must:

1. Be consistent with the medical standards and generally accepted practice parameters of *providers* in the same or similar general specialty as typically manages the condition procedure or treatment at issue; and
2. Help restore or maintain *your* health; or
3. Prevent deterioration of *your* condition; or
4. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Member

A *subscriber* or *dependent* who is enrolled under this *contract*.

Minimum Essential Coverage

Health care coverage as defined by the *Affordable Care Act* and codified in the Internal Revenue Code § 5000A(f), and any related regulations as they may be amended from time-to-time; which includes, but is not limited to, certain government-sponsored programs including a standard basic health plan (BHP) within the meaning of the *Affordable Care Act*, employer-sponsored plans, health plans offered in the individual market in a state; and which, if it is an employer-sponsored plan, provides minimum value, meaning that the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs.

Non-Participating Provider

A clinic, *physician*, *provider*, or facility that is licensed but is not a *participating provider*.

Non-Participating Provider Benefits

Coverage for *health care services* provided by licensed *providers* other than *participating providers*.

With *non-participating provider benefits*, *you* are financially responsible for a *deductible*, *coinsurance*, and any amount in excess of the *non-participating provider reimbursement value.*

Non-Participating Provider Reimbursement Value

The amount that will be paid by *us* to a *non-participating provider* for a non-*emergency* service is the least of the following:

1. a percentage of the *non-participating provider's* charge;
2. a percentage of an amount based on prevailing reimbursement rates or marketplace charges, for similar services and supplies, in the geographic area;
3. a percentage of the amount agreed upon between *us* and the *non-participating provider*; or
4. a percentage of the Medicare or other federal government program allowed amount in the geographic area in which the service is performed.

If one or more of the above options for determining the *non-participating provider reimbursement value* is not readily available, *we* may, at *our* discretion, determine the *non-participating provider reimbursement value* based on the least of the remaining options.

If the amount billed by the *non-participating provider* is greater than the *non-participating provider reimbursement value, you* must pay the difference. This amount is in addition to any *deductible* or *coinsurance* amount *you* may be responsible for according to the terms of this *contract*.

If *health care services* are delivered to *you* via telemedicine by a distant site *non-participating provider, we* will reimburse such *non-participating provider* on the same basis and at the same *non-participating provider reimbursement value* as would apply if the *covered services* had been delivered in person by the distant site *non-participating provider*.

Oral Surgery

Surgical services performed within the oral cavity.

Organ and Tissue Acquisition

The harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to *you*. This includes related medical expenses of a living donor.

Out-of-Pocket Limit

The maximum amount of money *you* must pay in *copayments, coinsurance* and *deductibles* before *we* pay remaining *eligible charges*. If *you* reach benefit, day, or visit maximums, *you* are responsible for amounts that exceed the *out-of-pocket limit.*

Participating Provider

A licensed clinic, *physician, provider* or facility that is directly contracted to participate in the specific *participating provider* network designated by *us* to provide benefits to *members* enrolled in this *contract*. The participating status of *providers* may change from time to time.

Participating providers may also be offered from other Preferred *Provider* Organizations that have contracted with *us*.

Participating Provider Benefits

Coverage for *health care services* provided through *participating providers*.

Physical Disability

A condition caused by a physical *injury* or congenital defect to one or more parts of *your* body that is expected to be ongoing for a continuous period of at least two years from the date the initial proof is supplied to *us* and as a result *you* are incapable of self-sustaining employment and are dependent on the *subscriber* for a majority of support and maintenance. An illness by itself will not be considered a *physical disability* unless adequate separate proof is furnished to *us* that allows *us* to determine that a *physical disability* also exists as defined in the preceding sentence.

Physician

A licensed Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Optometry, or Doctor of Chiropractic.

Post Service Claim

A request for payment of benefits that is made by *you* or *your* authorized representative after services are rendered and in accordance with the procedures described in this *contract.*

Premium

The total payment that *we* require be paid by *you* or on *your* behalf for the provision of the *covered services* listed in this *contract*.

Prescription Drug	A drug approved by the FDA for use only as prescribed by a *provider* properly authorized to prescribe that drug.
Pre-Service Claim	A claim related to services that have not yet been received and require a request for prior authorization for services that is made by *you* or *your* authorized representative in accordance with the procedures described in this *contract.*
Preventive Health Care Services	The *covered services* that are described in the Preventive Contraceptive Methods and Counseling for Women section and the *Preventive Health Care Services* section of this *contract.*
Primary Care Practitioner (PCP)	A doctor of medicine, *physician*'s assistant or nurse practitioner who is licensed or otherwise qualified under applicable law, who provides primary care services in the family medicine, general practice, internal medicine, OB/GYN or pediatrics areas of medical practice.
Provider	A health care professional, *physician*, or facility licensed, certified, or otherwise qualified under state law that delivers the *health care services* to *you.*
Qualified Health Plan	Health insurance coverage or a group health plan that the *Health Insurance Marketplace* certifies meets the criteria for certification required under the *Affordable Care Act*; that provides *essential health benefits*; and is offered by a health insurance issuer that meets the requirements of Section 1301(a)(1)(c) of the *Affordable Care Act,* and any related regulations as they may be amended from time-to-time.
Qualified Individual	An individual whom the *Health Insurance Marketplace* determines has met the eligibility requirements for enrolling through the *Health Insurance Marketplace* in a *qualified health plan* in the individual market, which requirements include, but are not limited to, citizenship, national status, or lawful presence in the United States; residency in a service area served by this *contract*; and not being incarcerated. Such residency requirement does not apply to *dependents.* An individual who, at the time of enrollment, is incarcerated, other than incarceration pending the disposition of charges, is not a *qualified individual*.
Reconstructive	*Medically necessary* surgery to restore or correct: 1. a defective body part, when such defect is incidental to or resulting from *injury*, *sickness*, or prior surgery of the involved body part; or 2. a covered dependent child's congenital disease or anomaly which has resulted in a functional defect as determined by a *physician.*
Reconstructive Surgery Following a Mastectomy	Coverage for *members* receiving *covered services* under this *contract* in connection with a mastectomy and who elect breast reconstruction in connection with such mastectomy will include: 1. all stages of reconstruction of the breast on which the mastectomy has been performed if the mastectomy was determined to be *medically necessary* by the attending *physician*; 2. surgery and reconstruction of the other breast to produce symmetrical appearance; 3. prostheses; and 4. treatment of physical complications at all stages of mastectomy, including lymphedemas.
Rehabilitative Care	Skilled restorative service that is rendered for the purpose of maintaining and improving functional abilities, within a predictable period of time (generally within a period of 6 months), to meet a *member*'s maximum potential ability to perform functional daily living activities. Not considered *rehabilitative care* are: *skilled nursing facility* care; home health services; speech, physical, and occupational therapy services for chronic medical conditions, or long-term disabilities, where progress toward such functional ability maintenance and improvement is not anticipated.

Rescission

A cancellation or termination of coverage that has retroactive effect. A cancellation or termination of coverage is not a *rescission* if:

1. the cancellation or termination has only a prospective effect,
2. the cancellation or termination is caused by *your* failure to timely pay *your* required *premiums*, or
3. the cancellation or termination is requested by *you* or *your* authorized representative and *we*, in *our* sole discretion, agree to allow such request.

Residential Treatment Facility

A facility that is licensed by the appropriate state agency and that provides 24 hour a day care, supervision, food, lodging, rehabilitation, or treatment for *sickness* related to mental health and substance use disorders.

Routine Patient Costs

The cost of any *covered services* that would typically be covered if *you* were not enrolled in an approved *clinical trial*. *Routine patient costs* do not include:

1. the cost of the *investigative* item, device, or service that is the subject of the approved *clinical trial.*
2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management.
3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sickness

Includes physical or mental illness or disease.

Skilled Care

Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to provide care or assess the *member's* changing condition. Long term dependence on respiratory support equipment does not in and of itself define a need for *skilled care*.

Skilled Nursing Facility

A Medicare licensed bed or facility (including an extended care facility, *hospital* swing-bed, and transitional care unit) that provides *skilled care*.

Specialist

Providers other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics.

Specialty Drugs

Injectable and non-injectable *prescription drugs*, as determined by *us*, which have one or more of the following key characteristics:

1. frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes;
2. intensive patient training and compliance assistance are required to facilitate therapeutic goals;
3. there is limited or exclusive product availability and/or distribution;
4. there are specialized product handling, storage and/or administration requirements; or
5. are produced by living organisms or their products.

Standard Reference Compendia

Any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

Stepchild(ren)

A natural or adopted child of the *subscriber's* lawful spouse.

Subscriber

The individual who submits an application for coverage, which may include application for coverage of any eligible *dependents* that the *subscriber* wishes to enroll, and, at the time of such application, is responsible for payment of *premium* and is not entitled to Part A or enrolled in Part B of Medicare.

Toileting

Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring

Moving into or out of a bed, chair or wheelchair.

Transplant Services	Transplantation (including retransplants) of the human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.
Urgent Care Center	A licensed health care facility that is designed primarily to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.
Urgent Claim	Any *pre-service claim* for *health care services* with respect to which the duration of the standard resolution process: 1. Could seriously jeopardize *your* life or health or *your* ability to regain maximum function, or 2. In the opinion of a *provider* with actual knowledge of *your* medical condition, would subject *you* to severe pain that cannot be adequately managed without the *health care service* that is the subject of the claim.
We, Us, Our	Refers to Aspirus Health Plan, Inc..
Web Based (Online) Care	Care provided by designated *participating providers* performed without physical face to face interaction, but through electronic (including telephonic) communication allowing evaluation, assessment and the management of services that leads to a treatment plan provided by a *participating provider* who is a licensed *physician* or a *participating provider* who is a qualified licensed health care professional. A list of *web based (online) care participating providers* may be obtained by calling Customer Service or by checking *our* website at www.aspirushealthplan.com. For purposes of this *contract*, a *participating provider* who contracts to be a designated *web based (online) care participating provider* shall not be treated or construed as performing telemedicine at a distant site.
You/Your	Refers to *member.*