CITIGROUP
GREEN BAY WI

Replacement HMO Certificate
Effective January 1, 2006
099747

Important Notice

To: WPS Prevea Health Plan Members
From: WPS Prevea Health Plan
Date: 1/1/06

Re: **Women's Health and Cancer Rights Act of 1998**

Coverage for breast reconstruction following a mastectomy has always been a covered benefit for WPS Prevea Health Plan members. In October 1998, Congress passed the Women's Health and Cancer Rights Act of 1998, also known as "Janet's Law," which requires all health plans and insurers to cover breast reconstruction following a mastectomy. The law calls for the following requirements:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis and coverage for any complications in all stages of mastectomy, including lymphedema.

All of WPS Prevea Health Plan's medical plans provide such coverage for breast reconstruction after a mastectomy. The coverage is subject to any deductible and copayments as described in your Schedule of Benefits and Certificate.

Please contact our Member Services Representatives at 490-6900 or toll-free at 888-711-1444 if you have any questions about this law and your WPS Prevea Health Plan coverage.

CERTIFICATE OF INSURANCE

WPS Health Plan, Inc.
2710 Executive Drive
Green Bay, WI 54304

(Referred to in the Certificate as "We", "Our" or "Us")

Plan Holder: CITIGROUP

WPS Health Plan, Inc. has entered into an agreement with the Plan Holder shown above to provide you with a health care benefit plan. WPS Health Plan, Inc. has issued and delivered to the Planholder a Master Contract that outlines the duties and obligations of the parties.

This is Your Certificate as long as You are eligible for insurance and You become and remain insured with WPS Health Plan, Inc. under this Plan. This Certificate explains the terms and conditions of Your insurance coverage. This Certificate is intended to present and explain the Plan in general terms. It is not the Plan contract (Master Contract) that has been issued to Your Employer. The Plan alone is the agreement under which payments are made. The Plan may be changed or canceled, according to its terms, without Your consent.

This Certificate replaces and supersedes any other Certificate that may have been issued previously. When We issue this certificate to You, We are not waiving the eligibility and effective date provisions found in the Plan.

We value Your partnership in maintaining Your health and well being. If You have any questions, please call Member Services at 1-888-711-1444 toll-free or 920-490-6900 locally.

NOTICE: If this Plan provides benefits for services rendered by Non-Participating Providers, this Plan limits the eligible expenses to the Usual and Customary charge for such services. This amount may be less than the billed charge. Please refer to the Definitions Provision for the definition of Usual and Customary and to the General Provisions for an explanation of the claim settlement practices in the Plan. For further information, contact:

GROUP CLAIM ADMINISTRATION
WPS HEALTH PLAN, INC.
P.O. Box 11625
Green Bay, WI 54307-1625
(920) 490-6900
(888) 711-1444

We will need the following information:

A. The name of the person for whom the claim will be made;
B. Social security number;
C. Practitioner/Hospital's zip code area;
D. Procedure code (CPT); and
E. Estimated Practitioner/Hospital charge.

Any information given by Us is subject to all Plan provisions at the time the claim is actually submitted.

WISCONSIN IMPORTANT NOTICE

You may resolve your problems by taking the steps outlined in the Grievance Procedure. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can contact the by writing to: **OFFICE OF THE COMMISSIONER OF INSURANCE**

COMPLAINTS DEPARTMENT
OFFICE OF THE COMMISSIONER OF INSURANCE
P.O. BOX 7873
MADISON, WI 53707-7873

Or you can call 1-800-236-8517 outside of Madison or 266-0203 in Madison, and request a complaint form.

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SCHEDULE OF BENEFITS

Group # 099747

The Schedule of Benefits outlines the level of coverage that Your Plan provides for each of the benefits specified in Your Certificate. All health benefits shown on this Schedule of Benefits are subject to the Individual Lifetime Maximum, Individual and Family Deductibles, Copays and Out-of-Pocket Maximums, unless otherwise indicated, and are subject to all provisions of this Plan.

The benefits provided by this Plan are payable only when services and treatment are received from a Participating Provider. Coverage will be provided for Covered Expenses received from Non Participating Providers in the event of an Emergency or for Urgent Care, or with an Authorization from Us. An Authorization is subject to the following requirements:

- Must be obtained by the Covered Person in consultation with his/her Primary Care Practitioner;
- Must be completed and submitted to Us;
- Must be approved by Us;
- Must be approved prior to services being rendered;

Certain covered services require a Pre-Service Authorization before benefits will be considered for payment. Refer to the Obtaining Services provision of this Plan for a description of these services and Authorization procedures.

The benefits provided by this Plan, unless otherwise specified, are subject to the following:

MAXIMUM BENEFITS PROVISION	
Individual Lifetime Maximum	$2,000,000
Deductible per calendar Year Individual Family	 $0 $0
Out-of-Pocket Maximum per calendar Year Individual Family	 $0 $0

SCHEDULE OF BENEFITS

Group # 099747

COVERED EXPENSES	MEMBER RESPONSIBILITY	
▪ ***PRIMARY CARE AND SPECIALTY SERVICES*** **Office Services** – Covered Expenses include Medically Necessary treatment rendered by Your Primary Care Practitioner or specialist's office on the same date of service, including but not limited to diagnostic x-ray and lab, and allergy testing, including allergy injections.	Copay per Office Visit Coinsurance After Deductible	$15 100% coverage + Waiver of Deductible
Office Diagnostic Tests – Covered Expenses include Medically Necessary x-ray and laboratory tests including but not limited to Medically Necessary ultrasound and nuclear medicine ordered by Your Practitioner.	Copay per Office Visit Coinsurance after Deductible	$15 100% coverage + Waiver of Deductible
Preventive Health Care and Routine Physicals – Covered Expenses include well person physical examinations, well baby visits, certain immunizations and vaccinations, and illness detection testing. Mammography is listed separately below. This includes 1 Routine Eye Exam per year, including eye refractions, and 1 Routine Hearing Exam per year. *Immunizations for Dependent children from birth to the age of 6 years are not subject to any Deductibles, Copays or Coinsurance.* ***Wellness Maximum Benefit per year is Unlimited***	Copay per Office Visit Coinsurance after Deductible	$0 100% coverage + Waiver of Deductible
Office Surgeries - Covered Expenses include Medically Necessary treatment rendered by Your Practitioner's office. The American Medical Association determines which procedures are regarded as office surgery.	Coinsurance after Deductible	100% coverage
Inpatient Practitioner Services – Covered Expenses include visits to a Hospital or Extended Care Facility by a Participating Provider.	Coinsurance after Deductible	100% coverage
Outpatient Practitioner Services – Covered Expenses include all related services for that Practitioner on the same date of service and billed in conjunction with Outpatient services.	Coinsurance after Deductible	100% coverage
▪ ***MAMMOGRAPHY*** Covered Expenses include at least one routine screening exam per Calendar Year for Covered Persons age 40 and over.	Coinsurance after Deductible	100% coverage + Waiver of Deductible
Diagnostic Mammograms ordered by Your Practitioner if performed in an office visit setting.	Copay per Office Visit Coinsurance after Deductible	$15 100% coverage + Waiver of Deductible

SCHEDULE OF BENEFITS

Group # 099747

COVERED EXPENSES	MEMBER RESPONSIBILITY	
▪ ***MATERNITY SERVICES***		
Prenatal – Covered Expenses include routine prenatal office visits and delivery performed by a Practitioner	Coinsurance after Deductible	100% coverage + Waiver of Deductible
Postnatal – Covered Expenses include a minimum of 48 hours Inpatient hospitalization following a vaginal delivery and a minimum of 96 hours Inpatient hospitalization following a cesarean section and 1postpartum visit.	Copay Per Hospital Stay Coinsurance after Deductible	$500 100% coverage + Waiver of Deductible
Newborn Benefits – Covered Expenses include Inpatient nursery expenses and Practitioner services.	Copay Per Hospital Stay Coinsurance after Deductible	$500 100% coverage + Waiver of Deductible
Office Diagnostic Tests –Covered Expenses include Medically Necessary x-ray and laboratory tests ordered by Your Practitioner	Copay per Office Visit Coinsurance after Deductible	$15 100% coverage + Waiver of Deductible
Non-Routine Prenatal Maternity Services – Covered Expenses include diagnostic services such as ultrasonography and amniocentesis.	Coinsurance after Deductible	100% coverage
▪ ***HOSPITAL SERVICES***		
Inpatient Hospital – Covered Expenses include Medically Necessary daily room and board in a semi-private room.	Copay Per Hospital Stay Coinsurance after Deductible	$500 100% coverage + Waiver of Deductible
Outpatient (Hospital or ambulatory surgery center) Covered Expenses include, but are not limited to, transfusion services, regularly scheduled chemo or radiation therapy, surgical procedures and other Medically Necessary procedures such as colonoscopy, endoscopy, laparoscopy and intravenous therapy.	Coinsurance after Deductible	100% coverage
Diagnostic Testing Covered Expenses include, but are not limited to, Diagnostic imaging (radiology) services, preoperative diagnostic testing, laboratory services, and cardiac diagnostic testing services as ordered by Your Practitioner.	Coinsurance after Deductible	100% coverage

SCHEDULE OF BENEFITS

Group # 099747

COVERED EXPENSES	MEMBER RESPONSIBILITY		
▪ ***EMERGENCY ROOM SERVICES AND URGENT CARE/WALK-IN***		*Participating Providers*	*Non Participating Providers*
Emergency - Covered Expenses for treatment of an Emergency will be provided without Prior Authorization. **Urgent Care** - Covered Expenses for treatment of an Urgent Care visit will be provided without Prior Authorization.	Copay per visit* Coinsurance after Deductible *Waived if admitted within 24 hours	$100 100% coverage + Waiver of Deductible	$200 100% coverage + Waiver of Deductible
• ***EMERGENCY TRANSPORTATION BENEFITS*** Covered Expenses include Emergency Ambulance Transportation as defined in the Definitions section.	Coinsurance after Deductible	100% coverage	
▪ ***CHIROPRACTIC SERVICES*** Covered services include Medically Necessary treatment and diagnostic tests. You may obtain services from a participating Chiropractor without being referred by your Primary Care Practitioner. Massage therapy is <u>not</u> covered. Maintenance therapy is <u>not</u> covered.	Copay per visit Coinsurance after Deductible	$15 100% coverage + Waiver of Deductible	
• ***THERAPY/PHYSICAL MEDICINE BENEFITS*** Covered Expenses for Medically Necessary physical medicine include physical modalities, therapeutic procedures, tests and measurements, manipulative treatment, biomechanical treatment, and neurophysiological treatment. Therapies include speech, physical, and occupational therapies.	Copay per visit Coinsurance after Deductible	$15 100% coverage + Waiver of Deductible	
• ***DURABLE MEDICAL EQUIPMENT (DME)*** Covered Expenses include Medically Necessary Durable Medical Equipment prescribed by Your Practitioner and needed in the treatment of an Illness or Injury, including Orthotics and Prosthetics. Covered Expenses are limited to the standard model.	Coinsurance after Deductible	100% coverage	

COVERED EXPENSES	MEMBER RESPONSIBILITY	
▪ ***TRANSPLANTS*** Covered Expenses include but are not limited to hospital charges, Practitioner charges, Organ and Tissue Acquisition, tissue typing and ancillary services at a Designated Transplant Facility that are Medically Necessary. Please refer to the Transplant provision for more information. ***Maximum Benefit per Transplant is the Usual and Customary Charge*** ***Aggregate Maximum for Travel and Housing is $10,000***	Coinsurance after Deductible	100% coverage
▪ ***EXTENDED CARE FACILITY SERVICES*** Covered Expenses include Medically Necessary room and board, miscellaneous services, supplies and treatments ***Maximum Benefit per Confinement is 30 days***	Coinsurance after Deductible	100% coverage
▪ ***HOME HEALTH CARE SERVICES*** Covered Expenses include Medically Necessary intermittent nursing care or home health aide services, therapies, medical supplies, drugs, or medication prescribed by a Practitioner, home visits by a Practitioner, and nutritional counseling ***Maximum Benefit per Plan Year is 40 visits***	Coinsurance after Deductible	100% coverage
▪ ***HOSPICE CARE*** Covered Expenses include, but are not limited to, medical services and supplies, counseling and home visits, except bereavement counseling.	Coinsurance after Deductible	100% coverage
▪ ***NERVOUS AND MENTAL DISORDERS, ALCOHOLISM AND DRUG ABUSE*** Inpatient Services maximum of 10 days inpatient per person per year Transitional Services maximum of 20 days transitional per person per year Outpatient visits maximum of 30 visits per person per year 1 day of inpatient Hospital treatment shall reduce transitional treatment benefits by 2 days. 2 days of transitional treatment shall reduce inpatient Hospital treatment benefits by 1 day. Please refer to the Benefits section of the Certificate of Coverage for additional information.	Coinsurance after Deductible Coinsurance after Deductible Coinsurance after Deductible	100% coverage + Waiver of Deductible 100% coverage + Waiver of Deductible 100% coverage + Waiver of Deductible

Group # 099747

COVERED EXPENSES	MEMBER RESPONSIBILITY	
▪ ***TEMPOROMANDIBULAR DISORDERS (TMJ)*** Covered Expenses include Medically Necessary diagnosis, surgical and non-surgical treatment of TMJ, including intraoral splint therapy devices. Maximum Benefit per calendar year for Diagnostic Procedures and non surgical Treatment is $1,250	Coinsurance after Deductible	100% coverage
▪ ***ALL OTHER COVERED EXPENSES***	Coinsurance after Deductible	100% coverage

SCHEDULE OF BENEFITS
PRESCRIPTION DRUG BENEFITS

COVERED PRESCRIPTION DRUGS (including prescription orders for covered disposable diabetic supplies – Formulary designation applies.)

If the Brand is dispensed when a Generic is available, the Covered Person will be responsible for the dollar amount difference between the Brand and Generic, plus any applicable Coinsurance and/or Copay.

Prescription drugs dispensed by a participating retail pharmacy as designated by Us:

Copayment/Coinsurance per new or refill Prescription Drug order for up to a continuous 30-day supply of medication or 1 cycle of oral contraceptives or hormone replacement therapy.

Generic Drug on the Drug Formulary	$10
Brand Name Drug on the Drug Formulary	$20
Brand Name Drug not on the Drug Formulary	$40

Prescription drugs dispensed by a participating mail order pharmacy as designated by Us:

Copayment/Coinsurance per new or refill Prescription Drug order for up to a continuous 90-day supply of medication or 3 cycles of oral contraceptives or hormone replacement therapy.

Generic Drug on the Drug Formulary	$20
Brand Name Drug on the Drug Formulary	$40
Brand Name Drug not on the Drug Formulary	$80

DEFINITIONS

Prescription Drug (also referred to as **Drug[s]** in this section) means any U.S. Food and Drug Administration (FDA) approved substance, whose label is required by law to bear the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription", "RX Only", or language with similar meaning. Insulin is considered a Prescription Drug under this benefit.

Prescription Order means the written or verbal request for a Drug by a person legally licensed to prescribe Drugs intended for human use. A separate Prescription Order is required for each Drug.

Contracted amount means the amount negotiated by Us or Our designee with the provider.

Generic means a Drug not protected by patent or trademark, or other Drugs as determined by Us or Our designee. Generic determinations by Us or Our designee are final.

Brand means the patent or trademark name of a Drug appearing on the manufacturer's label.

Drug Formulary means a select list of prescription Drugs and disposable diabetic supplies that is compiled by Us or Our designee for use by Practitioners. The Drug Formulary is reviewed and periodically modified with any changes effective as of the date of revision. Formulary designation may affect the Covered Person's financial responsibility for a Prescription Order.

BENEFITS

We will pay for Covered Expenses incurred by a Covered Person for the purchase of covered Drugs and disposable diabetic supplies. We will pay less the applicable Copayment and/or Coinsurance in the quantities described in the Schedule of Benefits. The Covered Person's responsibility under this benefit may not be used to satisfy the Plan Deductible Amount or Out-of-Pocket Expense maximum.

Covered Expenses for Medically Necessary Drugs and Disposable Diabetic Supplies:

A. Prescription Drugs;
B. Injectable Insulin;
C. Disposable Diabetic Supplies: insulin syringes, alcohol swabs, lancets, test strips;
D. Compounded drugs containing at least one Prescription Drug.
E. Drugs that by law required a written prescription and are prescribed by a Practitioner for the purpose of smoking cessation. Limited to a maximum of one continuous three-month course of pharmacotherapy per Calendar Year.
F. Prescription Drugs for the treatment of HIV infection or an Illness or medical condition arising from or related to HIV that are prescribed by a Practitioner and are approved by the Federal Food and Drug Administration (FDA), including phase 3 Experimental or Investigational drugs that are FDA approved and are administered according to protocol.

CONDITIONS AND LIMITATIONS

A. At Our discretion, some Drugs may require prior authorization before being covered.
B. Quantity limits may be enforced on specific Drugs to ensure the appropriate amounts are dispensed.
C. Age and/or gender edits may be enforced to ensure appropriate prescribing.
D. If the Brand is dispensed when a Generic is available, the Covered Person will be responsible for the dollar amount difference between the Brand and Generic, plus any applicable Coinsurance and/or Copay.
E. Drugs will be included on the Drug Formulary at the sole discretion of Us or Our designee.
F. Copayments and/or Coinsurance apply to each 28-day cycle for oral contraceptives or hormone replacement therapy.
G. Prescription refills may not be obtained until 75% of the previous supply has been used.
H. We, at Our sole discretion, determine which Drugs can be obtained through the mail order pharmacy in supplies greater than that available from a retail pharmacy.
I. Drugs may not be mailed outside of United States.

EXCLUSIONS

A. Any expense excluded by the Exclusions and Limitations section;
B. Charges in excess of the contracted amount regardless of a provider's participating status.
C. Charges in excess of the Generic contracted amount when a Generic substitute for a Brand name is available.

D. Immunizations, vaccines, biological sera, blood, or other blood products unless described elsewhere.
E. Drugs labeled: “Caution – Limited by Federal Law to Investigational Use” or similar language indicating the drug is Experimental and any related services.
F. FDA approved Drugs used for Experimental and/or unapproved indications unless sufficient evidence for their use can be found in the United States Pharmacopoiea, National Formulary, AHFS Drug Evaluations, or primary medical literature. We have sole discretion for determining whether sufficient evidence exists.
G. Any charge in excess of the contracted dispensing fee for administration, compounding, mixing, or packaging of a covered Drug.
H. Charges properly covered by another insurance or government program.
I. Replacement medications needed due to loss, theft, or damage.
J. Drugs that can be obtained without a prescription and any drug that is equivalent to a non-prescription medication.
K. Drugs used for weight control or whose primary use is weight control.
L. Any Drug used for cosmetic purposes or whose use is not Medically Necessary.
M. Drugs to treat toenail or fingernail fungus.
N. Any compounded Drug that is substantially like a commercially available product.
O. Any specialty compounded hormone prescription.
P. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits section.
Q. Drugs used for fertility or whose primary use is fertility.
R. Drugs from Non Participating pharmacies except for Emergencies outside of the Geographical Service Area.
S. Injectable contraceptives and any contraceptive device other than diaphragms.
T. Any medical supply not noted elsewhere.
U. Any Drug which is to be taken or administered in a Hospital, provider’s office, Extended Care Facility, rehabilitation hospital, or similar institution.
V. A covered Drug related to a non-covered medical encounter.
W. Anabolic steroids, unless prior authorization is obtained.
X. Injectable medications except as determined by Us or Our designee.
Y. Drugs used for impotence, or whose primary use is impotence, or to enhance sexual activity.
Z. Non legend vitamins, minerals and supplements even if prescribed by a Practitioner.
AA. Any charge for the administration of Prescription legend drugs or injectable insulin.

CHOOSING A PRIMARY CARE PRACTITIONER

The objective of Our primary care entry concept is to guide Covered Persons into an ongoing relationship with a Primary Care Practitioner. The Primary Care Practitioner coordinates medical care for each Covered Person. This provides for better medical care because the Primary Care Practitioner:

- Assures that appropriate, cost-effective care is being given in the right setting
- Avoids duplicate care
- Monitors prescription drug interactions
- Is cost effective

When a Covered Person first becomes eligible for coverage under this Plan, such Covered Person must designate a Primary Care Practitioner. A Covered Person can change their Primary Care Practitioner at any time. However, We encourage each Covered Person to establish a relationship with one doctor. In addition, We must be notified each time a Covered Person selects a different Primary Care Practitioner.

HOW TO ACCESS HEALTH CARE SERVICES

Covered Persons have a broad choice of Participating Providers. Our website at www.wpspreveahealthplan.com contains the most current listing of Participating Providers included in Our network. Our Provider Directory can also be used as a resource. Refer to www.wpspreveahealthplan.com or call Us for information regarding Participating Providers before making an appointment.

The benefits provided by this Plan are payable only when services and treatment are received:

A. From a Participating Primary Care Practitioner.
B. From a Participating Provider subject to the Authorization Requirements in the next bolded section.

The benefits provided by this Plan are also payable when services are rendered by:

A. Radiologists in the following settings:
   1. Inpatient - At a Participating Hospital or with an Authorization approved by Us to a Non Participating Hospital.
   2. Outpatient - From a Participating Radiologist or by a Radiologist that is on staff at a Participating Hospital or with an Authorization approved by Us to a Non Participating Hospital.
   3. Non Participating Radiology services when ordered by a Participating Provider.
B. Pathologists in the following settings:
   1. Inpatient - At a Participating Hospital or with an Authorization approved by Us to a Non Participating Hospital.
   2. Outpatient - From a Participating Pathologist or by a Pathologist that is on staff at a Participating Hospital or with an Authorization approved by Us to a Non Participating Hospital.
C. Anesthesiologists in the following settings:
   1. Inpatient - At a Participating Hospital or with an Authorization approved by Us to a Non Participating Hospital
   2. Outpatient - For services provided in association with a surgical procedure from a Participating anesthesiologist on staff at a Participating facility or with an Authorization approved by Us to a Non Participating Hospital.
   3. For services not associated with a surgical procedure, an Authorization approved by Us is necessary.
D. Participating Chiropractors
E. Participating Optometrists for routine eye care
F. Participating Ophthalmologists for routine eye care
G. Non Participating Providers only when the authorization Requirements provision is met
H. Urgent Care and Emergency Care Facilities

AUTHORIZATION REQUIREMENTS

An Authorization is required when a Covered Person receives covered services from any Participating Provider who is a specialist or any Non Participating Provider. An Authorization is subject to the following requirements:

A. Must be obtained by the Covered Person in consultation with his/her Primary Care Practitioner;
B. Must be completed and submitted to Us via phone, fax, or written form;
C. Must be approved by Us;
D. Must be approved by Us prior to services being rendered;

E. Must be obtained for any Participating Provider who is a specialist or any Non Participating Providers;
F. Shall be valid for only:
   1. The Covered Person for whom the Authorization was made;
   2. The services specified in the Authorization and approved by Us; and
   3. The period of time specified and approved by Us.

Covered Persons are not required to obtain Authorization for covered obstetrical or gynecological treatment by a Participating Provider who specializes in obstetrics and gynecology.

It is the Covered Person's responsibility to follow all Authorization requirements. If a Covered Person receives services or treatment from a Non Participating Provider with an approved Authorization from Us, Usual and Customary charges will apply.

STANDING AUTHORIZATIONS

The Covered Person has the right to request a standing Authorization to a specialist.
A standing Authorization is subject to the following requirements:

A. Must be obtained by the Covered Person in consultation with his/her Primary Care Practitioner;
B. Must be completed and submitted to Us;
C. Must be approved by Us;
D. Must be approved prior to services being rendered;
E. Must be obtained for all specialists, including Participating Providers;
F. Shall be valid for only:
   1. The Covered Person for whom the Authoriztion was made;
   2 The services specified in the Authorization and approved by Us; and
   3 The period of time specified and approved by Us.

It is the Covered Person's responsibility to follow all Authorization requirements. If a standing Authorization is approved, the Covered Person may request that the designated specialist provide primary care services, provided that the specialist is a Participating Provider, and the Covered Person's Primary Care Practitioner agrees. Any other Authorization requests will need to be made by the Covered Person's Primary Care Practitioner.

PRE-SERVICE AUTHORIZATION

Certain Covered Services require Pre-Service Authorization. A Pre-Service Authorization is an authorization to the Covered Person from Us approving coverage of certain Covered Services prior to the Covered Person receiving those services. Pre-Service Authorization does not guarantee benefit coverage.

Covered services requiring Pre-Service Authorization include, but are not limited to, the following:

A. Inpatient stay in an Extended Care Facility, Birthing Center or Hospital;
B. Organ and tissue transplants;
C. Home Health Care;
D. Durable Medical Equipment over $500 or any Durable Medical Equipment rentals;
E. Home infusion;
F. Prosthetics over $1,000;
G. An Expense Incurred for Nervous and Mental Disorders, Alcoholism and Drug Abuse.

All Pre-Service Authorization requests must be approved by Us before Covered Services are provided to the Covered Person. All Authorization Requests are effective as of the date approved by Us.

Failure to obtain approved Authorization Requests, when required by Us, may result in those services not being covered by the Plan, or covered at a different level. There is no coverage for services that We determine are not Medically Necessary. Coverage for services remains subject to all terms and conditions of the Plan.

UTILIZATION MANAGEMENT PROGRAMS

Utilization Management is included in this Plan to encourage quality medical care on the most cost effective and appropriate basis. The benefit amounts payable under the Schedule of Benefits may be affected if the requirements described for Utilization Management are not satisfied

Covered Persons will receive benefits under the Plan only when services are determined to be

Medically Necessary. The fact that a Practitioner has prescribed, ordered, recommended, or approved a treatment, service or supply, or has informed the Covered Person of its availability does not in itself make it Medically Necessary. We will make the final determination of whether any service constitutes Medically Necessary care as defined by the Plan.

We use the following methods to coordinate and review care, and to determine whether services are Medically Necessary.

A. Utilization Review. Utilization Management is included in this Plan to encourage quality medical care on the most cost effective and appropriate basis. The benefit amounts payable under the Schedule of Benefits may be affected if the requirements described for Utilization Management are not satisfied.
B. Concurrent Review. Concurrent review is the ongoing review of the Medical Necessity of any Inpatient Hospital admissions and certain Outpatient services.

   An Inpatient Hospital confinement will be reviewed to determine an appropriate length of stay. Coverage will not be provided for extra days that are not approved by Us. Outpatient services subject to concurrent review may include, but are not limited to:

   1. Durable Medical Equipment
   2. Home health care
   3. Hospice care
   4. Nervous and Mental Disorders, Alcoholism and Drug Abuse
   5. Care received in an Extended Care Facility
C. Discharge Planning. Discharge planning assists Covered Persons with the transition to an appropriate level of care following acute Inpatient and/or Outpatient health care services. If the Covered Person is not able to return home, We will help coordinate the Covered Person 's care to identify the most appropriate alternative setting and services. It is the Covered Person's responsibility to ensure that the care is provided by a Participating Provider.
D. Case Management. Case management is early identification and ongoing management of Covered Persons with complex diagnoses, catastrophic Injuries or Illnesses, chronic health problems, or poor histories of self-management or compliance. Case management involves coordination of the Covered Person 's health care needs and a treatment plan. The Covered Person, Utilization Management Department staff, family members, and/or a Participating Provider may initiate case management.

CONTINUITY OF CARE

Under certain circumstances, if a Covered Person's Primary Care Practitioner or specialist physician leaves Our network, the Covered Person may continue to receive care from that Practitioner or physician.

We will continue to provide coverage for services from a Participating Provider who terminates participation with the Plan, under the following circumstances:

A. The provider continues to practice within the Geographical Service Area.
B. The provider's Participation with Us did not terminate because of the provider's misconduct.
C. We represented that the provider was, or would be, a Participating Provider in marketing materials provided or available to the Covered Person at the time of the Covered Person's initial enrollment, most recent coverage renewal, or most recent open-enrollment period, whichever is later.
D. If the provider is the Covered Person's Primary Care Practitioner at the time the provider's participation terminates, We will continue to cover services provided by that Practitioner until the end of the Plan Year for which We represented that the provider was, or would be, a Participating Provider.
E. If the Covered Person is undergoing a course of treatment with a provider other than the Covered Person's Primary Care Practitioner at the time the provider's participation terminates, We will continue to cover non-maternity services from that provider for the following period of time:
   1. For the remainder of the course of treatment;
   2. For 90 days after the provider's participation terminates; or
   3. Until the end of the current plan year for which We represented that the provider was, or would be, a Participating Provider, whichever is shorter.
F. If the Covered Person is receiving maternity care from a provider other than the Covered Person's Primary Care Practitioner, and the

Covered Person is in the second or third trimester of pregnancy when the provider's participation terminates, We will continue to cover services from that provider until the completion of postpartum care for the mother and infant.

We will pay for Covered Expenses incurred by Covered Persons for an Illness or Injury, subject to any Deductibles, Coinsurance, maximums and limits **shown on the Schedule of Benefits**. Benefits are based on Our negotiated rate or the Usual and Customary charge. The following services are covered subject to the terms and conditions set forth in this Certificate.

- Primary Care and Specialty Services
- Mammography
- Maternity Services
- Hospital Services
- Emergency Room Services
- Urgent Care / Walk-In
- Emergency Ambulance Transportation
- Chiropractic Services
- Therapies and Physical Medicine
- Genetic counseling, studies and testing
- Durable Medical Equipment (DME), Supplies, and Prosthesis
- Transplants
- Extended Care Facility Services
- Home Health Care
- Hospice Care
- Nervous and Mental Disorders, Alcoholism and Drug Abuse
- Dental Services
- Temporomandibular Disorders (TMJ)
- All Other Covered Services

PRIMARY CARE AND SPECIALTY SERVICES

Office Services

We will pay Covered Expenses for Medically Necessary treatment rendered by Your Primary Care Practitioner's or specialist's office. These Covered Expenses include but are not limited to office visits, diagnostic x-ray and lab, allergy testing, and allergy injections.

Preventive Health Care and Routine Physicals

We will pay Covered Expenses for preventive health care incurred by a Covered Person. Covered Expenses for preventive health care must:

A. Be ordered by a Practitioner;
B. Be provided by a Participating Provider;
C. Be expenses for care to:
    1. Evaluate or assess health and well being;
    2. Screen for possible detection of unrevealed Illness;
    3. Improve health; or
    4. Extend life expectancy;
C. Not be for the diagnosis and treatment of an Illness or Injury.

Covered Expenses include:

A. Well person physical examinations;
B. Well baby visits;
C. The following immunizations and vaccinations:
    1. Diptheria;
    2. Pertussis;
    3. Tetanus;
    4. Poliomyelitis;
    5. Measles;
    6. Mumps;
    7. Rubella;
    8. Haemophilus influenzae type B;
    9. Hepatitis B;
    10. Varicella;
    11. Influenza;
    12. Pneumococcal;
    13. Meningococcal;
D. Age-appropriate screening diagnostic studies and physical exams*, including, but not limited to:
    1. Routine screening mammograms for women age 40 and over subject to a maximum of one (1) mammogram per Calendar Year;
    2. Screening colonoscopy and flexible sigmoidoscopy at appropriate time intervals*;
    3. Bone mineral density studies such as DEXA scanning at appropriate time intervals*;
    4. Laboratory or other diagnostic studies to screen for clinically unrevealed disease/illness;
    5. One (1) routine eye exam per year including eye refractions;
    6. One (1) routine hearing screening exam per year;
    7. One (1) nutritional counseling visit per year;
    8. Screening tests for lead exposure for dependent children under 6 years of age in accordance with the recommendation set forth in the Wisconsin Department of Health & Family Services Guidelines;

9. One (1) administrative exam or exam requested by a third party provided to an eligible Dependent for participation in school, sports, camp, scouting, or other activity requiring such pre-participation exam.

*As recommended by the US Preventative Services Task Force

Immunizations for Dependent children from birth to the age of 6 years are not subject to any Deductibles, Copays or Coinsurance under this Plan.

Some laboratory and diagnostic studies may be subject to a Copay, Deductible, or Coinsurance if determined not to be part of a routine wellness or screening examination.

Expenses that are paid under any other benefit provision of this Plan are not payable under this provision. For additional information, please refer to the Exclusions and Limitations section.

Office Surgeries

We will pay Covered Expenses for Medically Necessary treatment rendered by Your Practitioner's office. Please refer to the Exclusions and Limitations section for any exclusions or limitations.

Practitioner Services

A. Inpatient - We will pay Covered Expenses for Inpatient Practitioner services including visits to a Hospital and Extended Care Facility by Participating Providers.
B. Outpatient - We will pay covered expenses for Outpatient Practitioner services including all related services for that Practitioner on the same date of service and billed in conjunction with Outpatient services.

For additional information, please refer to the Exclusions and Limitations section.

MAMMOGRAPHY

Coverage for mammography includes the following:

A. Diagnostic mammograms ordered by Your Practitioner; and
B. Routine screening mammograms for women age 40 and over subject to a maximum of one mammogram per Calendar Year.

For additional information, please refer to the Exclusions and Limitations section.

MATERNITY SERVICES

Covered Expenses include:

A. Prenatal exams and testing, delivery, and 1 postpartum visit.
B. Routine nursery expenses and Practitioner services for the newborn.

Delivery includes a minimum of 48 hours Inpatient hospitalization following a vaginal delivery and a minimum of 96 hours Inpatient hospitalization following a cesarean section. Please refer to the Effective Date Provisions section for enrollment requirements for newborns. For additional information, please refer to the Exclusions and Limitations section.

HOSPITAL SERVICES

Covered Expenses include:

A. Hospital room and board at the semi-private rate. Any charge over a semi-private room charge will be a Covered Expense only if determined by Us to be Medically Necessary;
B. Hospital miscellaneous services;
C. Practitioner services;
D. X-ray and laboratory tests;
E. Radiation therapy and chemotherapy;
F. Blood and blood plasma that is not replaced;
G. Anesthetics and oxygen and their administration;
H. Drugs which require a Practitioner's written prescription and which are administered while an Inpatient;

For additional information, please refer to the Exclusions and Limitations section.

EMERGENCY ROOM SERVICES/ URGENT CARE WALK-IN

Emergency Room and Urgent Care services are Covered Expenses and do not require prior authorization. Whenever possible, it is important to use a Participating Provider for Emergency Room and Urgent Care services. We may deny

Emergency care charges if the medical condition did not need Emergency care as determined by Us. Emergency medical services and urgent care are also covered for a Dependent who is a full-time student living out of the Geographical Service Area.

For additional information, please refer to the Exclusions and Limitations section.

AMBULANCE TRANSPORTATION

A. Emergency - We will pay for ambulance transportation in a medical Emergency to the closest facility able to provide the specialized treatment required. Whenever possible, it is important to express your preference to be transported to a Participating Provider for Emergency services.
B. Non-Emergency – We will pay for transportation between facilities to obtain Medically Necessary care when You are confined to a Hospital or Extended Care Facility. All non-Emergency transportation must be Authorized by Us.

We will pay for the mode of transportation consistent with the well being of the Covered Person. If You are transported to a Non-Participating Provider, You may be requested to transfer to a Participating Provider when Your condition stabilizes.

For additional information, please refer to the Exclusions and Limitations section.

CHIROPRACTIC SERVICES

We will pay for Medically Necessary spinal manipulation and diagnostic tests. You may obtain services from a Participating chiropractor without an Authorization by your Primary Care Practitioner. Please refer to the Therapy and Physical Medicine section for physical therapy. For additional information, please refer to the Exclusions and Limitations section.

THERAPY AND PHYSICAL MEDICINE

Physical Medicine services include, but are not limited to:

A. Physical modalities;
B. Therapeutic procedures;
C. Tests and measurements;
D. Manipulative treatment;
E. Biomechanical treatment;
F. Neurophysiological treatment.

Covered Expenses include:

A. Speech therapy by a Qualified speech therapist or speech and language pathologist;
B. Physical therapy by a Qualified physical therapist;
C. Respiratory therapy by a Qualified respiratory therapist;
D. Occupational therapy by a Qualified occupational therapist;
E. Massage and aquatic therapy as ordered by a Practitioner and provided by a Qualified physical therapist or occupational therapist as part of the Covered Person's treatment plan; or
F. Benefits specifically related to a learning disability and/or developmental delay are limited to an evaluation visit and a maximum of 3 follow up visits per therapy per Calendar Year. Actual treatment of these conditions is not covered. The therapies may include physical, speech, and occupational therapy. The purpose of the therapies are for home instruction and monitoring for long-term and/or maintenance conditions.

For therapy services to be covered, it must be demonstrated that the Covered Person is making interval progress based on documentation of therapy visits. Therapy services must address a particular condition or Illness, and demonstrate progress toward a specific outcome or treatment goal as determined by Us.

For additional information, please refer to the Exclusions and Limitations section.

GENETIC COUNSELING, STUDIES, AND TESTING

Must Be Authorized By Us.
Refer to Obtaining Services Provision

We will cover genetic testing and/or counseling if determined to be Medically Necessary as determined by Us. In order for services to be covered, it must be shown that performing such testing and/or counseling will directly impact treatment of the Covered Person or provide data to the Covered Person in order to make an informed decision regarding future treatment. Services for genetic counseling, studies and testing must be Authorized by Us.

For additional information, please refer to the Exclusions and Limitations section.

DURABLE MEDICAL EQUIPMENT (DME), SUPPLIES, AND PROSTHESIS
Must Be Authorized By Us.
Refer to Obtaining Services Provision

Rental or purchase of wheelchairs, Hospital type beds, oxygen equipment (including oxygen), and other Durable Medical Equipment are covered subject to the following:

A. The equipment must be prescribed by a Practitioner and needed in the treatment of an Illness or Injury and will be provided on a rental basis for the period of treatment. At Our option, such equipment may be purchased. If the equipment is purchased, benefits will be payable for subsequent repairs necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be payable subject to approval by Us. Subsequent repairs due to abuse or misuse, as determined by Us, are not covered;
B. Benefits will be limited to the standard models, as determined by Us;
C. We will pay benefits for only ONE of the following: a manual wheelchair, a motorized wheelchair, or motorized scooter, as determined by Us;
D. The maximum benefit payable for orthopedic modification shall be limited to one pair of shoes per calendar year unless necessitated by growth or change in condition.
E. Durable Medical Equipment over $500, any Durable Medical Equipment rentals, and Prosthetics over $1,000 require a Pre-Service Authorization.

Covered Expenses include but are not limited to:

A. Casts, splints, crutches, trusses, braces, or custom molded orthotics.
B. Installation and use of an insulin infusion pump and associated supplies. Covered Expenses for an infusion pump are limited to one pump per year. The Covered Person must use the pump for 30 days before We consider it a Covered Expense. Replacement batteries are not covered.
C. Initial external prostheses following a mastectomy and one extender prostheses every 3 years thereafter. Replacement bras are covered up to two bras per year.
D. Support stockings to include two per affected leg per year.
E. Penile prostheses (e.g. Erectaid) when impotence:
    1. is caused by an organic dysfunction; or
    2. is a complication that is a direct result of a covered surgery; or
    3. is a result of an injury to the genitalia or spinal cord; and other accepted treatment has been unsuccessful
F. Artificial limbs, eyes, and larynx.

For additional information, please refer to the Exclusions and Limitations section.

TRANSPLANTS
Must Be Authorized By Us.
Refer to Obtaining Services Provision

We will pay for Covered Expenses incurred by a Covered Person at a Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Coinsurance, maximums or limits **shown on the Schedule of Benefits**.

It will be the Covered Person's responsibility to obtain prior Authorization for all transplant related services. If prior Authorization is not obtained, benefits will not be payable for such services. The approved transplant and medical criteria for such transplant must be considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the transplant is recommended.

We will pay for approved Transplant Services, subject to the following provisions:

A. Organ and Tissue Acquisition and transplantation, including any post-transplant complications, if a Covered Person is the recipient; or
B. Related medical care, including any post-harvesting complication, if a Covered Person is a donor.

Covered Expenses for Transplant Services include services and supplies for Authorized transplants when ordered by a Practitioner. Services include, but are not limited to, Hospital charges, Practitioner charges, Organ and Tissue Acquisition, tissue typing, and ancillary services.

Benefits are payable for the following Authorized transplants:

A. Kidney;
B. Kidney/Pancreas;
C. Liver;
D. Heart;
E. Heart/Lung;
F. Lung;
G. Bone Marrow (allogenic and autologous) for certain conditions;
H. Stem cell transplants for certain conditions;
I. Small Bowel Transplantation; and
J. Cornea

SECOND OPINION

We will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the Designated Transplant Facility, We will refer them to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility or any Non-Designated Transplant Facility accepts the Covered Person for the procedure.

TRAVEL EXPENSES

If a transplant is performed at a Designated Transplant Facility, We will pay for the following, subject to the maximum shown on the Schedule of Benefits:

A. Transportation to and from the Designated Transplant Facility for:
    1. The Covered Person; and
    2. One or two parents of the Covered Person (if the Covered Person is a Dependent child, as defined in this Plan); or
    3. A Close Relative or other person to accompany the Covered Person;
B. Lodging at or near the Designated Transplant Facility for the Covered Person and/or family member(s) who accompanied the Covered Person while the Covered Person is receiving transplant-related services at such Designated Transplant Facility.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the Designated Transplant Facility.

For additional information, please refer to the Exclusions and Limitations section.

EXTENDED CARE FACILITY SERVICES
Must Be Authorized By Us.
Refer to Obtaining Services Provision

Covered Expenses include:

A. Room and board: We will pay for the standard semi-private room daily rate. Benefits will not be less than the maximum daily rate established by the Department of Health and Family Services.
B. Miscellaneous services, supplies and treatments provided by an Extended Care Facility.

Covered Expenses are limited to the number of days shown on the Schedule of Benefits.

For additional information, please refer to the Exclusions and Limitations section.

HOME HEALTH CARE
Must Be Authorized By Us.
Refer to Obtaining Services Provision

Covered Expenses include the following services, subject to the maximum shown on the Schedule of Benefits:

A. Intermittent Nurse Services;
B. Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist;
C. Medical supplies, drugs, or medication prescribed by a Practitioner, and laboratory services to the extent that We would have covered them under this Plan if the Covered Person had been in a Hospital;
D. Home visits by a Practitioner which:
    1. Are in lieu of visits to the Practitioner's office;

2. Do not exceed the Usual and Customary charge to perform the same service in a Practitioner's office;

F. Intermittent home health aide services which are Medically Necessary as part of a home care plan, under the supervision of a registered nurse or medical social worker which consist solely of caring for the Covered Person; or

G. Nutrition counseling provided by or under the supervision of a certified or registered dietitian.

For additional information, please refer to the Exclusions and Limitations section.

HOSPICE CARE
Must Be Authorized By Us.
Refer to Obtaining Services Provision

Coverage is provided for Covered Persons who are terminally ill and accepted as Hospice Program participants. To be eligible for Hospice Care, You must be terminally ill with a life expectancy of six months or less if the Illness runs its course. Covered Persons who elect to receive Hospice Care do so in lieu of curative treatment for their terminal illness while they are enrolled in Hospice Care.

The Hospice Program provides or arranges for services related to the terminal illness and assures continuity of patient/family care in home, Outpatient or Inpatient settings, including a Hospice Care Facility. Covered Expenses include the following services:

A. Core services which include:
   1. Nursing services 24 hours a day, seven days a week;
   2. Medical social worker services;
   3. Dietary, spiritual and bereavement counseling;

B. Services of a Practitioner;

C. Physical, occupational or speech therapy;

D. Homemaker or home health aide services;

E. Inpatient care in a facility when needed for pain control, other acute and chronic symptom management or respite care;

F. Pharmacy services; and

G. Durable Medical Equipment.

A Pre-Service Authorization is required for Hospice Care. Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility. For additional information, please refer to the Exclusions and Limitations section.

NERVOUS AND MENTAL DISORDERS, ALCOHOLISM AND DRUG ABUSE

All treatment or services for this benefit, including any initial visits, must be certified by Us or a designee authorized by Us prior to receiving the treatment or services.

Nervous and Mental Disorders means a condition listed in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Disease (ICD-9-CM) within a classification category and code as follows:

A. 291 Alcohol psychoses;
B. 292 Drug psychoses;
C. 295 Schizophrenic psychoses;
D. 296 Affective psychoses;
E. 297 Paranoid states;
F. 298 Other nonorganic psychoses;
G. 300 Neurotic disorders;
H. 301 Personality disorders;
I. 302 Sexual deviations and disorders;
J. 306 Physical conditions arising from mental factors;
K. 307 Special symptoms or syndromes not elsewhere classified;
L. 308 Acute reaction to stress;
M. 313 Disturbance of emotions specific to children and adolescence;
N. 314 Hyperkinetic syndrome of childhood, including Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder;
O. 315 Specific delays in development;
P. 309 Adjustment and anxiety disorders;
Q. 312 Conduct, behavioral and impulse control disorders.

Collateral means a member of a Covered Person's immediate family and is limited to the spouse, Children, parents, grandparents, brothers and sisters of the Covered Person and their spouses.

Hospital as used in this provision shall mean:

A. A Hospital licensed under s.50.35 which is devoted primarily to the diagnosis, treatment of, and medical or surgical care for three or more nonrelated individuals who suffer from Illness, disease, injury, etc.

B. An approved public treatment facility which is a treatment agency that operates under the direction and control of the Department of Health and Family Services (DHFS) or provides treatment for Nervous and Mental Disorders, alcoholism or drug abuse either through a contract with DHFS or the local county mental health board. The facility must meet the standards established by DHFS and must be approved by DHFS.
C. An approved private treatment facility is one which meets the standards established by DHFS and is approved by DHFS. The only difference between it and a public treatment facility is that the private treatment facility does not have a contract with DHFS or the local county mental health board.

Outpatient Services mean nonresidential services provided to a Covered Person or a Collateral by any of the following:

A. A program in an Outpatient treatment facility if approved by DHFS and if established and maintained according to the rules promulgated by DHFS.
B. A licensed Physician who has completed a residency in psychiatry.
C. A licensed psychologist who is listed in the National Register of Health Service Providers in Psychology.

In order to be listed in the National Register of Health Services Providers in Psychology, a psychologist must:

A. Be currently licensed by the Psychology Examining Board at the independent level of psychology;
B. Have a doctoral degree in psychology from an accredited institution; and
C. Have two years supervised experience in health service in psychology of which at least one year is in an organized health service training program and one year post doctoral.

Covered Expenses are:

A. Participating Providers:

    1. Inpatient Hospital treatment limited to the first 10 days per Calendar Year ; or
    2. Medically Necessary transitional treatment programs, limited to the first 20 days of treatment per Calendar Year. One day of Inpatient Hospital treatment shall reduce transitional treatment benefits by 2 days. 2 days of transitional treatment shall reduce inpatient Hospital treatment benefits by 1 day.
    3. Outpatient treatment limited to the first 30 visits per Calendar Year.

Covered Expenses for transitional treatment programs or services must be:

A. Determined by Us to be Medically Necessary; and
B. Listed in the State of Wisconsin Program Certification Directory under one of the following categories:
    1. Mental health services for adults in a day treatment program offered by a provider certified by DHFS under Wisconsin Regulation s. HFS 61.75.
    2. Mental health services for Children and adolescents in a day treatment program offered by a provider certified by DHFS under Wisconsin regulation s. HFS 40.04.
    3. Services for persons with chronic Mental Illness provided through a community support program certified by DHFS under Wisconsin regulation s. HFS 63.03.
    4. Residential treatment programs for alcohol or drug dependent persons or both certified by DHFS under Wisconsin Regulation s. HFS 75.14 (1) and (2).
    5. Services for alcoholism and other drug problems provided in a day treatment program certified by DHFS under Wisconsin Regulation s. HFS 75.12 (1) and (2).
    6. Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine.
    7. Coordinated emergency mental health intervention services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services are provided by a program certified by DHFS under Wisconsin regulation HFS 34.03 and provided in accordance with subch. III HSF ch. 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or

referred to other providers for stabilization.

For additional information, please refer to the Exclusions and Limitations section.

NERVOUS AND MENTAL DISORDERS, ALCOHOLISM AND DRUG ABUSE FOR FULL-TIME STUDENTS

A full-time student attending School outside of the Geographical Service Area, but within the State of Wisconsin, will have benefits available for limited outpatient services received from Non Participating Providers for Nervous and Mental Disorders, alcoholism and drug abuse. Prior to receiving services under this provision, such student must undergo a clinical assessment. If Outpatient services are recommended in the clinical assessment, not more than five visits to a Non Participating Provider Outpatient treatment facility or other provider will be payable.

All Non Participating Provider Outpatient treatment facilities or providers must be located in the State of Wisconsin and in reasonable proximity to the School in which the student is enrolled. If the Plan determines the treatment will prevent the student from attending School on a regular basis or the student is no longer enrolled in School, Non Participating Provider services will not be payable. Upon completing the five visits, continuing care by the Non Participating Provider must be approved by the Plan.

For purposes of this provision, **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.

All benefits provided under this provision are subject to the maximum benefit limitations contained in the Schedule of Benefits for Nervous and Mental Disorders, alcoholism and drug abuse.

For additional information, please refer to the Exclusions and Limitations section.

DENTAL SERVICES

Covered Expenses include:

A. Charges for treatment of Injuries to natural teeth, including replacement of such teeth, or for setting of a jaw that was fractured or dislocated in an Accident. However, the charges must be incurred within 12 months after the Accident or within 12 months of becoming covered under this Plan, whichever is later;

B. Hospital or ambulatory surgery center expenses, including anesthetics in conjunction with dental care that is provided to a Covered Person. Covered Expenses are payable only if any of the following apply:
   1. The Dependent is under the age of five;
   2. The Covered Person has a **chronic disability**; and
   3. The Covered Person has a medical condition that requires hospitalization or general anesthesia for dental care.

   A **chronic disability** must meet all of the following conditions:

   A. It is attributable to mental or physical impairment or combination of mental and physical impairments;
   B. It is likely to continue indefinitely;
   C. It results in substantial functional limitations in one or more of the following areas of major life activity:
      1. Self-care;
      2. Receptive and expressive language;
      3. Learning;
      4. Mobility;
      5. Capacity for independent living; and
      6. Economic self-sufficiency.

Benefits are not payable for cosmetic or elective orthodontic care, periodontal care, oral surgery for bony impacted wisdom teeth, or general dental care. For additional information, please refer to the Exclusions and Limitations section.

TEMPOROMANDIBULAR DISORDERS (TMJ)

Covered Expenses are payable for Medically Necessary diagnostic procedures and surgical and non-surgical treatment for the correction of TMJ, including intraoral splint therapy devices. Covered Expenses are payable only if all of the following apply:

A. The disorder is caused by congenital, developmental or acquired deformity, disease or injury;
B. The procedure or device is reasonable and appropriate for the diagnosis or treatment of

the disorder according to the accepted standards of the profession of the health care provider providing the service; and

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

Benefits are not payable for cosmetic or elective orthodontic care, periodontal care or general dental care. For additional information, please refer to the Exclusions and Limitations section.

OTHER COVERED SERVICES

A. Second Opinions:

Covered Expenses are payable for a second opinion from another Participating Provider.

B. Voluntary sterilization

C. Cardiac Rehabilitation:

1. Phase I, while the Covered Person is an Inpatient;
2. Phase II, while the Covered Person is Outpatient. Services must begin within 30 days after discharge from the Hospital.

D. Breast Reconstruction:

Covered Expenses are payable for breast reconstruction of the affected tissue incident to a mastectomy. Covered Expenses include surgery and reconstruction of the other breast to produce a symmetrical appearance, prosthesis, and complications of mastectomies, including lymphedema.

E. Diabetes:

Covered Expenses are payable for the treatment of diabetes, diabetic self-management education programs, and the use of an insulin infusion pump or other equipment or supplies, including insulin, and any prescription medication used to treat diabetes. Prescription drugs approved for the treatment of diabetes, including insulin are subject to the annual Deductible and Coinsurance as outlined in the Schedule of Benefits, unless coverage is provided elsewhere in this Plan. Covered Expenses for an infusion pump are limited to one pump per year. The Covered Person must use the pump for 30 days before We consider it a Covered Expense.

F. Kidney Disease:

Covered Expenses are payable for the treatment of kidney disease, including dialysis, kidney transplantation, and donor-related services. When the transplant recipient is a Covered Person, donor-related services are Covered Expenses. When only the donor is a Covered Person, no expense for donor-related services would be covered.

G. Reconstructive Surgery:

We will pay Covered Expenses for reconstructive surgery for the treatment of the following:

1. Congenital Illness or anomaly that resulted in a functional defect;
2. Abnormality resulting from an Accident. Such surgery must occur within 12 months of the Accident or within 12 months of becoming covered under this Plan, whichever is later;
3. Abnormality resulting from infection or other disease of the involved part. Such surgery must occur within 12 months of the diagnoses of the initial abnormality or within 12 months of becoming covered under this Plan, whichever is later;
4. Breast reconstruction of affected tissue incident to a mastectomy, and reconstruction of the other breast as necessary to produce a symmetrical appearance.

For additional information, please refer to the Exclusions and Limitations section.

Accident means unexpected or unintended Injury caused by contact with another body or object, which is unrelated to any:

A. Pathological;
B. Functional; or
C. Structural disorder.

Actively At Work means actively working at Your regular duties full time for a minimum of 30 hours per week, at Your employer's regular place of business or at some other place to which Your employer's business requires You to travel. You will be considered at work on a day that is not a scheduled workday if You were at work on the last scheduled workday.

Activities Of Daily Living (ADL) means the following, with or without assistance:

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

Authorization means the written form from Your Primary Care Practitioner requesting specific services to be provided by certain Participating Providers and any Non Participating Providers.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant woman under the direction and supervision of one or more Practitioners specializing in obstetrics, general practice, family practice or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Calendar Year means the period of time from January 1 through December 31.

Certificate means the Certificate of Coverage, which is issued to Covered Persons, which summarizes the terms, conditions, and limitations of Your group health care coverage.

Close Relative means a member of Your or Your spouse's immediate family. Immediate family includes mother, father, grandmother, grandfather, stepparents, step grandparents, siblings, stepsiblings, half siblings, children, stepchildren and grandchildren.

Coinsurance means the percentage We pay for certain Covered Expenses after the Calendar Year or Plan Year Deductible(s) and copays are met. You will be responsible for the difference for any remaining charges due to the provider.

Contracted amount means the amount negotiated by Us or Our designee with the Participating Provider.

Copay (copayment) is the amount **shown on the Schedule of Benefits**, which may be required to be paid to the provider at the time services are received. Copays do not apply toward satisfaction of the Individual or Family Deductible or Out-of-Pocket Maximum. The Office Visit copay applies to all related services for that Practitioner on the same date of service including but not limited to diagnostic x-ray and lab, and allergy testing, including allergy injections. The urgent care copay and Emergency care copay apply to all related services billed on the same date of service.

Cosmetic Treatment means medical or surgical procedures to alter normal structures of the body, as determined by Us, in order to improve appearance, treat a Mental and Nervous Disorder or to improve self-esteem.

Covered Expenses means any charge incurred, or portion thereof, which is eligible under this Plan.

Covered Person means You and/or Your covered Dependent(s).

Creditable Coverage means coverage under the following:

A. A group health plan;
B. Health insurance or Health Maintenance Organization coverage;
C. Medicare;
D. Medicaid;
E. Military health care;
F. A medical care program of the Indian Health Services or of a tribal organization;
G. A state health benefits risk pool;
H. A health plan offered under the Federal Employee Health Benefits Program;
I. A public health plan as defined under Federal regulations;
J. A health benefit plan under Section 5(e) of the Peace Corps Act; or
K. A State Children's Health Insurance Program (S-Chip).

Creditable Coverage does not include coverage where there was a Significant Break in Coverage, which means a period of more than 63 consecutive days during all of which a person does not have any Creditable Coverage. A Waiting Period is not counted in determining a Significant Break in Coverage.

Custodial or Maintenance Care is care received after the Covered Person has achieved a maximum level of improvement or plateau in progress as determined by Us. The determination of Custodial or Maintenance Care is made by Us after reviewing a Covered Person's case history or treatment plan submitted by a Practitioner.

Deductible is the amount of Covered Expenses which must be incurred before benefits are payable. The Schedule of Benefits shows the amount of the Deductible and the Health Care benefits to which it applies.

If You have family coverage, when Covered Expenses incurred by:

A. You and two or more of Your Dependents; or
B. Three or more of Your Dependents

equal the Family Deductible amount, the Family Deductible will be considered met for You and all of Your Dependents for the remainder of the Calendar Year or Plan Year. This applies even if no individual Covered Person has incurred Covered Expenses equal to the Individual Deductible.

All Covered Expenses accumulated towards the Deductible under the Plan Holder's prior group plan, if any, may be used to meet the Deductible under this Plan during this Plan's first year. The Covered Person must submit proof that the prior Deductible was met or partially satisfied.

Dependent means:

A. Your legal spouse so long as he or she is not covered as an Employee under this Plan. When a person is no longer Your legal spouse, that person no longer qualifies as Your Dependent.
B. Each Dependent Child until that Child reaches the age of 19. Coverage may continue to age 25 if such child is in regular full-time attendance at an accredited secondary, vocational, technical, or adult education school, or an accredited college or university. Proof of attendance will be required upon request by Us. Full-time student status is defined as 12-15 credits per semester, or as defined by the institution, which the student is attending. A Child will not be covered if he or she:
    1. Is married; or
    2. Is covered as a Dependent of another Employee; or
    3. Is employed on a regular full time basis; or
    4. Is eligible for his or her own medical insurance under this Plan or another group policy.

In addition to the termination provisions outlined in the Individual Termination Date Provision or the Group Termination Provision, a Dependent's coverage under this Plan ends when any of the following events occur:

1. When he/she enters the armed forces on active duty (other than duty of less than 30 days); or
2. When he/she is divorced from the Covered Person who is a subscriber under the Plan; or
3. When his/her total benefits reach the amount of the lifetime benefit maximum under the Plan; or
4. When he/she is disenrolled as stated in the Individual Termination Provisions; or
5. When his/her eligibility period under any continuation coverage provision expires.

The term **Child** includes:

A. A natural Child;
B. A step Child;
C. A legally adopted Child or a Child legally Placed for Adoption;
D. A Child under Your legal guardianship; and
E. A Grandchild until Your Dependent parent Child reaches age 18.

If You have a Dependent Child covered under this Plan who is mentally retarded or physically handicapped, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan as shown in the definition of "Dependent". You must submit proof that the Child meets these conditions within 31 days after the day coverage would normally end. We may, for two years, ask for additional proof at any time, after which We can ask for proof not more than once a year. We may require the Dependent to be examined by a Participating Provider for the purpose of determining the existence of the incapacity prior to continuing coverage. You must notify Us immediately of a cessation of incapacity or dependency. Coverage will continue for as long as he or she is:

A. Chiefly dependent on You and Your spouse for support and maintenance; and
B. Not able to hold a self-sustaining job due to the mental retardation or physical handicap.

Designated Transplant Facility means a facility, which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network with which We have a contract.

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

Durable Medical Equipment is equipment which:

A. Is designed for repeated use; and
B. Is intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and
C. Generally is not useful to a person in the absence of an Illness or Injury.

Emergency means a medical condition of a Covered Person that has a recent onset and that manifests itself by symptoms of sufficient severity, including severe pain, that would lead a prudent lay person who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

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

Emergency Ambulance Transportation means professional ambulance transportation in a medical Emergency, which is:

A. To the closest facility able to provide the specialized treatment required; and
B. The most appropriate mode of transportation consistent with the well being of the Covered Person.

Employee/Full Time Employee means a person who is Actively At Work for the Plan Holder, but does not include:

A. A member of the Plan Holder's Board of Directors, an owner, partner or officer unless engaged in the conduct of the Plan Holder's business on a full time basis; or
B. An independent contractor or consultant who is paid on other than a regular wage or salary by the Plan Holder.
C. Part-time or temporary employees are not eligible Employees under this Plan.

Enrollment Date means:

A. For other than a Late Enrollee, the first day of coverage for You and Your Dependent(s) or, if

there is a Waiting Period, the first day of the Waiting Period;

B. For anyone who enrolls on a special enrollment date, the Enrollment Date is the first day of coverage;

C. For a Late Enrollee, the Enrollment Date is the first day of coverage.

Exclusion means any service or supply listed in the Exclusions and Limitations section. Such services or supplies listed as Exclusions are not covered by Us, regardless of their Medical Necessity or their approval or prescription by a physician or other provider.

Expense Incurred means the charge for a service, treatment, supply or facility. The expense is considered to be incurred on the date the service or treatment is given, the supply is received or the facility is used.

Experimental or Investigational means the use of services, treatment, supplies or facilities that include, but are not limited to, one of the following:

A. Are not currently recognized as accepted medical practice as determined by Our Medical Director;

B. Were not recognized as accepted medical practice at the time the charges were incurred, as determined by Our Medical Director;

C. Have not been approved by the United States Federal Drug Administration upon completion of Phase III clinical investigation;

D. Have not successfully completed all phases of clinical trials;

E. A treatment protocol based upon or similar to those used in incomplete clinical trials;

F. Based on review of prevailing peer reviewed medical literature in the United States, there is failure to demonstrate, at a minimum, an equivalent clinical outcome when compared to standard/conventional treatment for the condition; or

G. Based on review of prevailing peer reviewed medical literature in the United States, there is failure to demonstrate the treatment is safe and effective for the condition.

A service, supply, treatment or facility may be considered Experimental or Investigational and not Medically Necessary, even if the provider/ Practitioner has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition.

Extended Care Facility means an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Practitioner or registered nurse. This includes, but is not limited to, a skilled nursing, sub acute or rehabilitation facility. In addition, We require that the facility:

A. Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength;

B. Is not a place primarily for Custodial or Maintenance Care;

C. Requires compensation from its patients;

D. Admits patients only upon Practitioner orders;

E. Has an agreement to have a Practitioner's services available when needed;

F. Maintains adequate medical records for all patients; and

G. Has a written transfer agreement with at least one Hospital.

Geographical Service Area of the WPS Health Plan, Inc. means the following Wisconsin counties:Brown, Calumet, Door, Fond du Lac, Kewaunee, Manitowoc, Marinette, Oconto, Outagamie, Shawano, Sheboygan, Waupaca, and Winnebago.

Grievance means any dissatisfaction with the administration, claims practices, or provision of services by Us that is expressed in writing to Us by, or on behalf of, a Covered Person.

Grievance Review Panel means a group consisting of Our representative, a plan medical representative and a Covered Person.

Habilitative Services means services which are educational in scope and purpose and are rendered to develop, improve or accelerate functions that have never been present or are not present to the normal degree of function for that persons like age and sex.

Home Health Care means a formal program of care and treatment that is:

A. Performed in the home;

B. Prescribed by a Practitioner;

C. Intermittent care and treatment for the recovery of health or physical strength under an established plan of care;
D. Prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay;
E. Provided or coordinated by a state-licensed or Medicare-certified home health agency or certified rehabilitation agency;
F. Appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

Hospice Care means care that is part of a Hospice Program given to Covered Persons who are Terminally Ill.

Hospice Program means an agency or organization that:

A. Has Hospice Care available 24 hours a day, seven days a week;
B. Is certified by Medicare as a Hospice Program, and, if required, is licensed as such by the jurisdiction in which it is located;
C. Provides core services which include:
    1. Nursing services 24 hours a day, seven days a week;
    2. Medical social worker services;
    3. Dietary, spiritual and bereavement counseling.
D. Provides or arranges for other services as related to the Terminal Illness which will include:
    1. Services of a Practitioner;
    2. Physical, occupational or speech therapy;
    3. Homemaker or home health aide services;
    4. Inpatient care in a facility when needed for pain control, other acute and chronic symptom management or respite care;
    5. Pharmacy services; and
    6. Durable Medical Equipment.
E. Assures continuity of patient/family care in a home, Outpatient and Inpatient setting.

Hospice Care Facility means a facility or distinct part of a Hospital or Extended Care Facility that:
A. Obtained approval of any required state or governmental certificate of need;
B. Provides 24 hour, seven days a week service;
C. Has at least one of each of the following personnel:
    1. Doctor of Medicine (MD);
    2. Registered nurse (RN);
    3. Licensed or certified social worker;
    4. Pastoral or other counselor;
    5. Full-time administrator.
D. Is responsible for continuing to directly provide core services while the Covered Person is receiving care and services;
E. Provides Inpatient Hospice Care as its primary purpose;
F. Maintains written records of services;
G. Has been established and operated in accordance with the applicable laws in the area in which it is located.

Hospital means a facility licensed as an acute Hospital and:

A. Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons as Inpatients;
B. Has a staff of one or more licensed Practitioners available at all times;
C. Always provides 24 hour nursing services by registered graduate nurses; and
D. Is not a place primarily for Custodial or Maintenance Care.

Hospital includes:
A. Extended Care Facility;
B. Surgical Center; and
C. Birthing Center.

Independent Review means the process to provide You an opportunity to have medical professionals who have no connection to Your health plan review Your dispute regarding a medical judgment.

Illness means sickness or disease. Pregnancy and complications of pregnancy are considered an Illness under this Plan.

Infertility is not a Covered Expense. Infertility means the inability or diminished ability to produce offspring, including but not limited to a couple's failure to achieve pregnancy during 1 year of unprotected intercourse, or when a woman repeatedly fails to carry a pregnancy to fetal viability. Repeated failures to carry a pregnancy

means 3 consecutive documented spontaneous abortions in the first or second trimester. Please refer to the Exclusions and Limitations section for any exclusions or limitations.

Infertility or Fertility Treatment means services, tests, supplies, devices, or drugs, which are intended to:

A. Promote fertility;
B. Achieve and maintain a condition of pregnancy;
C. Treat an Illness causing an Infertility/fertility condition when such treatment is done in an attempt to bring about or maintain a pregnancy or increase the chances of pregnancy occurring; or
D. Diagnose Infertility or its etiology.

For purposes of this definition, Infertility or Fertility Treatment includes, but is not limited to:

A. Fertility tests and drugs;
B. Tests and exams done to prepare for or follow through with induced conception;
C. Surgical reversal of a sterilized state which was a result of a previous surgery;
D. Sperm enhancement procedures;
E. Direct attempts to cause or maintain pregnancy by any means including, but not limited to:
    1. Hormone therapy or drugs;
    2. Artificial insemination;
    3. In vitro fertilization;
    4. GIFT or ZIFT;
    5. Embryo transfer; and
    6. Freezing or storage of embryo, eggs, or semen.
F. Evaluation and treatment of habitual abortions (3 consecutive documented spontaneous abortions in the first or second trimesters) when not pregnant.

Injury means the result of an act causing harm or damage to the body.

Inpatient means a registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Late Enrollee means a person who enrolls under this Plan other than on:

A. The earliest date on which coverage can become effective under the terms of this Plan; or
B. A special enrollment date for the person. See the Effective Date Provision for details on special enrollment periods.

Lifetime Maximum means the maximum amount each Covered Person is eligible to receive for Covered Expenses in his or her lifetime, under this Plan and any other WPS Health Plan, Inc. coverage. The Covered Person's overall Lifetime Maximum if applicable is stated on the Schedule of Benefits and includes other applicable benefit maximum specifically stated in the Schedule of Benefits.

Medically Necessary means services, treatment, supplies, or facilities, which We determine to be:

A. Consistent with and appropriate for the diagnosis or treatment of the Covered Person's Illness or Injury;
B. Commonly and customarily recognized and generally accepted by the medical profession in the United States as appropriate and standard care for the condition being evaluated or treated;
C. The most appropriate and cost effective level of care which can safely be provided to the Covered Person;
D. Proven to be useful, likely to be successful, yield additional information or to improve clinical outcome; and
E. Not primarily for the convenience or preference of the Covered Person, his or her family or any provider.

A service, supply, treatment or facility may not be considered Medically Necessary, even if the provider or Practitioner has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Non-designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with which We have a contract. This may include facilities that are listed as Participating Providers.

Non Participating or **Non Participating Provider** means that the person, entity or institution has not entered into a written agreement with Us to provide covered services to the Covered Person.

Nurse Services means Intermittent home nursing care by professional registered nurses or by licensed practical nurses. Services may include:

A. Assessment of the total needs of the Covered Person;
B. Planning of the Covered Person's care;
C. Observing, monitoring and recording the Covered Person's response to treatment; or
D. Monitoring, observing and evaluating the drug regimen.

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

Out of Pocket Maximums are **shown on the Schedule of Benefits**. After an individual or family has met their respective Out-of-Pocket Maximums during a Calendar Year or Plan Year, We will pay 100 percent of certain Covered Expenses incurred during the remainder of that Calendar Year or Plan Year. Deductible(s) will count toward satisfaction of the applicable Out-of-Pocket Maximum.

The following will not be used to meet the Out-of-Pocket Maximums:

A. copays;
B. Penalties;
C. Mental and Nervous Disorders, alcoholism and substance abuse expenses;
D. Any charges above the limits specified elsewhere in this Plan.

You and Your Dependents are required by this Plan to pay any Out-of-Pocket Expenses. This requirement cannot be waived by You or Your provider under any "fee forgiveness", no "Out-of-Pocket" or similar agreement. You must notify Us if You have entered into an agreement with Your provider to waive any Deductible, copay or required Coinsurance.

Outpatient means other than an Inpatient.

Participating or **Participating Provider** means that the person, entity, or institution has entered into a written agreement with Us to provide covered services to the Covered Person. This may include any Practitioner, Hospital, pharmacy, clinic, Extended Care Facility, Surgical Center or other health care provider. The participation status may change from time to time. Refer to the Provider Directory or contact Us for a listing of the Participating Providers.

Physical Medicine means the treatment given to relieve pain, restore or, improve function to its maximum potential. Services include, but are not limited to:

A. Physical modalities;
B. Therapeutic procedures;
C. Tests and measurements;
D. Manipulative treatment;
E. Biomechanical treatment;
F. Neurophysiological treatment.

Placed For Adoption means:

A. The department, a county department under s.48.57(1)(e) or (hm) or a Child welfare agency licensed under s.48.60 places a Child in Your home for adoption and enters into an agreement under s.48.833 with You.
B. A court under s.48.837(6)(b) orders a Child placed in Your home for adoption.
C. A sending agency, as defined in s.48.988 (2)(d), places a Child in Your home under 48.988 for adoption, and You take physical custody of the Child at any location within the United States.
D. The person bringing the Child into the State of Wisconsin has complied with s.48.98, and You take physical custody of the Child at any location within the United States.
E. A court of foreign jurisdiction appoints You as guardian of a Child who is a citizen of that jurisdiction, and the Child arrives in Your home for the purpose of adoption by You under s.48.839.

Plan or Plan Holder means policy and policyholder, respectively.

Planholder Document or Master Contract means the document issued to the Plan Holder.

Plan Year means the period beginning on the effective date of the Group's Plan and running 12 consecutive months.

Practitioner means any of the following licensed Practitioners who perform service payable under this Plan: a Doctor of Medicine (MD), a Doctor of Osteopathy (DO), a Doctor of Podiatric Medicine (DPM), a Doctor of Dental Surgery (DDS), a Doctor of Dental Medicine (DMD), a Doctor of Chiropractic (DC) or a Doctor of Optometry (OD), nurse practitioner, physical therapist, occupational therapist, speech therapist and audiologist; or any other licensed Practitioner that We are required to reimburse, acting within the scope of their license and performing a service which would be payable under this Plan when performed by an MD.

Preexisting Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within six consecutive months ending on the Enrollment Date.

Pre-Service Authorization means the process of receiving written approval from Us for certain services or products in advance of the service or product being provided.

Prescription Drug (also referred to as **Drug[s]** in this certificate) means any U.S. Food and Drug Administration (FDA) approved substance, whose label is required by law to bear the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription", "RX Only", or language with similar meaning. Insulin is considered a Prescription Drug under this benefit.

Primary Care Practitioner means a participating Practitioner who practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology. When a Covered Person first becomes eligible for coverage under this Plan, such Covered Person must designate a Primary Care Practitioner. The Covered Person may designate a different Primary Care Practitioner at any time by notifying Us. Each Covered Person may select a different Primary Care Practitioner.

Provider Directory means a list of the Participating Providers and Practitioners. For current participation status of the specific provider, contact Us at the telephone number shown on Your identification card, or go to Our website at www.preveahealthplan.com.

Qualified means licensed, registered or certified by the state in which the provider practices.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, Accident, or Illness. It is generally performed to achieve a normal appearance and may also be performed to improve or restore function.

Retired Employee means a person who was employed full time by the Plan Holder who is no longer Actively At Work and who is now retired under the Plan Holder's formal retirement program.

Schedule of Benefits means the summary of Covered Expenses provided by Us in this Certificate.

Skilled Care means Custodial or Maintenance Care.

Surgical Center means a licensed facility:

A. Under the direction of an organized medical staff of Practitioners;
B. With permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
C. With continuous Practitioner services and registered professional nursing services available whenever a patient is in the facility;
D. Which generally does not provide Inpatient services or other accommodations; and
E. Which offers the following services whenever the patient is in the center:
    1. Provides drug services as needed for medical operations and procedures performed;
    2. Provides for the physical and emotional well being of the patients;
    3. Provides Emergency services;
    4. Has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using the Internet, interactive audio, video, or data communications.

Telemedicine does not include teleradiology in this Plan.

Total Disability means for an Employee or his or her employed covered spouse, that the person is at all times prevented from engaging in any job or occupation for wage or profit. For a covered spouse who is not employed and a covered Dependent child, Total Disability means a disability preventing the person from engaging in substantially all of the usual and customary activities of a person in good health and of the same age and sex. Total Disability is determined by Us based upon medical opinion and other appropriate resources.

Transplant Services means approved services and supplies for Authorized transplants when ordered by a Practitioner. Such services include, but are not limited to, Hospital charges, Practitioner's charges, organ and tissue procurement, tissue typing and ancillary services.

Urgent Care means care received for an Illness or Injury with symptoms of sudden or recent onset that require medical care the same day. Such care must be rendered at a licensed Urgent Care Facility and be required in order to prevent the condition from getting worse before a Covered Person is able to reach a Participating Provider.

Usual and Customary means the amount We determine to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. **Geographical Area** means a zip code area, or a greater area if We determine it is needed, to find an appropriate cross section of accurate data.

Utilization Management means a formal assessment of the Medical Necessity, effectiveness, and appropriateness of health care services and treatment plans on a prospective, concurrent, or retrospective basis.

Waiting Period means a period of time that must pass before coverage begins for You or Your Dependent who enrolls under this Plan.
We, Our, Us means WPS Health Plan, Inc.

You, Your means You, the Employee, or, where applicable, any Covered Person.

We will not pay for Expenses Incurred for the following services, medical procedures, or supplies. In addition to those exclusions listed below, the Benefits section contains exclusions specific to the benefits provisions listed in that section.

COSMETIC/RECONSTRUCTIVE SURGERY

A. Cosmetic Surgery or Treatment or any portion thereof, as determined by Us.
B. Reconstructive Surgery performed only to achieve a normal or nearly normal appearance, or any portion thereof, as determined by Us, unless provided elsewhere in this Plan.
C. The following procedures:
    1. Injection of filling material (collagen) other than for incontinence;
    2. Salabrasion;
    3. Rhytidectomy (face lift);
    4. Dermabrasion;
    5. Chemical peel;
    6. Suction-assisted lipectomy (liposuction);
    7. Electrolysis;
    8. Mastopexy;
    9. Mammoplasty, augmentation or reduction mammoplasty (cosmetic enhancement of breast appearance with or without breast implants except for reconstruction following treatment for breast cancer);
    10. Correction of inverted nipples;
    11. Sclerotherapy for spider veins;
    12. Panniculectomy;
    13. Mastectomy for male gynecomastia;
    14. Botox

DENTAL SERVICES

A. The following charges for dental services:
    1. The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment;
    2. Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances;
    3. Dental implants;
    4. Orthognathic surgery or any surgical procedure performed to correct deformities of the mandible or maxilla, correction of malocclusion, or orthodontic treatment (eg braces);
    5. Tooth extraction of any kind, including oral surgery for bony impacted wisdom teeth.

The only covered dental services are limited to the services listed as Covered Expenses under Dental Services in the Benefits section of this Certificate.

DRUGS

A. Outpatient prescription drugs or medicines unless benefits are provided elsewhere in this Plan. Drugs or medicines administered while in the Hospital or Practitioner's office are a Covered Expense.
B. Drugs filled by a Hospital or Practitioner's office, unless benefits are provided elsewhere in this Plan.
C. Non-prescription vitamins, minerals and supplements, even if prescribed by a Practitioner.
D. All enteral feedings, supplemental feedings, over-the-counter nutritional and electrolyte supplements and related supplies including feeding tubes, pumps, bags and products.
E. Medications used to treat sexual dysfunction or to increase sexual function or satisfaction.
F. Drugs that can be obtained without a prescription and any drug that is equivalent to a non-prescription medication.

DURABLE MEDICAL EQUIPMENT

A. Modifications to Your vehicle, home or property, such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, chair lifts, grab bars or ramps.
B. Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.
C. Wigs, toupees, hairpieces, cranial prosthesis, hair implants or transplants or hair weaving.
D. Routine periodic maintenance of Durable Medical Equipment and replacement of batteries.

GENERAL EXCLUSIONS

A. Services, supplies, facilities or equipment that We determine are not Medically Necessary.

B. Services, supplies, facilities or equipment that We determine are Experimental or Investigational.

C. An Illness or Injury for which the Covered Person is entitled to or receives a benefit under a federal, state, county, municipal, or other governmental agency or law now existing, or subsequently enacted or amended, such as Medicare, Workers Compensation, and Veterans Administration programs covering service-connected disabilities or conditions.

D. An Illness or Injury caused by any military related act or incident of declared or undeclared war, riots, insurrection or acts of terrorism.

E. An Illness or Injury sustained by a Covered Person of the armed services of any country that occurred:
   1. While on active duty; or
   2. As a result of the Covered Person being on active duty.

F. Medical care received during a stay in a Hospital owned or operated by a federal, state, province or political unit unless required by statute or regulations.

G. Custodial or Maintenance Care.

H. Charges or the portion thereof which is in excess of the Usual and Customary charge.

I. Illness or Injury while:
   1. Committing or attempting to commit a civil or criminal battery or felony;
   2. Engaging in an illegal occupation.

   This would not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

J. Services performed by a Close Relative or by someone who ordinarily lives in the Covered Person's home.

K. Services for pervasive developmental disorders, including autism, are for a diagnostic evaluation only. Other services specifically for pervasive developmental disorders are not covered, except limited coverage for learning disabilities or Developmental Delay as specifically listed in the Benefits provision of this Certificate.

L. General fitness programs, exercise programs, exercise equipment and health club memberships.

M. Drugs, medicines, procedures, services and supplies for, or leading to, sex transformation surgery.

N. Any treatment or therapy that is court ordered, ordered as a condition of parole, probation, or custody evaluation, except for coverage that must be provided as required under s. 609.65, Wis. Stats., for a person examined, evaluated or treated for a nervous or mental disorder pursuant to an emergency detention, a commitment or a court order.

O. Telephone consultations in the absence of a Practitioner/patient relationship or completion of claim forms or forms necessary for the return to work or school.

P. An appointment the Covered Person did not attend.

Q. Telemedicine, except teleradiology.

R. Services, supplies, equipment and facilities under more than one provision of the Plan. Covered Expenses will be considered for payment under only one provision.

S. Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are provided to the Covered Person at no cost.

T. Services, supplies, facilities or equipment for complications resulting from an elective surgery that is excluded under this Plan.

U. A physical exam requested by a Third Party for employment, licensing, insurance, marriage, adoption, travel, or court ordered exams.

V. Cranial banding.

W. Private duty nursing.

X. Personal comfort or convenience items.

Y. Marriage counseling.

Z. Reversal of voluntary sterilization.

AA. Travel and transportation for a consultation or to receive treatment, except for approved ambulance services, as specifically provided in the Benefits section of this certificate.

BB. Bereavement counseling unless provided as part of Hospice coverage.

CC. Any health care, services or treatment that are excluded elsewhere in this Plan.

DD. All services not specifically identified as being covered in this plan.

EE. Services provided before the Covered Person’s coverage is effective.

FF. Services provided after the Covered Person’s coverage terminates. If a Covered Person is receiving inpatient care in a Hospital on the date his/her coverage terminates, benefits will continue for Covered Expenses incurred for that Confinement. Coverage may continue for

a Covered Person that is Totally Disabled as described in the Group Termination Provision.

GG. Services and/or supplies provided without a required Authorization or if Authorization was denied.

GENETIC COUNSELING, STUDIES, AND TESTING

A. Genetic counseling, studies and testing, except the coverage that is specifically provided in the Benefits section of this certificate.

HEARING SERVICES

A. The purchase or fitting of hearing aids.
B. Diagnostic tests, surgery, devices and related instruction or therapy for cochlear implants.
C. Augmentation communication devices and related instruction or therapy.

HOSPITAL SERVICES

A. Hospital stays if care could be provided in a less acute setting.

INFERTILITY

A. Infertility or Fertility Treatment and direct attempts to achieve pregnancy or increase chances of achieving pregnancy by any means.

MATERNITY SERVICES

A. Birthing classes, including Lamaze classes.
B. Abortions unless the mother's life would be in danger, as determined by Us. If complications arise after the performance of any abortion, expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.
C. Surrogate mother services.
D. Home births.

NERVOUS AND MENTAL DISORDERS, ALCOHOLISM AND DRUG ABUSE

A. Substance abuse or chemical dependency (alcohol or other drug abuse) charges over and above the Wisconsin state mandated benefits.
B. Nervous and Mental Disorders charges over and above the Wisconsin state mandated benefits.

PREVENTIVE HEALTH SERVICES

A. Any immunization or vaccination other than those listed in the Preventive Health Care section of the Benefits provision of the certificate.
B. Preventive care received from a Non Participating Provider.

REHABILITIATION SERVICES

A. Vocational or industrial rehabilitation including work hardening programs.
B. Cardiac rehabilitation beyond Phase II.
C. Habilitative Services.

THERAPIES

A. Long-term therapy and maintenance therapy. Examples of long-term/maintenance conditions that are not covered include but are not limited to learning disabilities such as attention deficit, hyperactivity disorder, sensory defensiveness, auditory defensiveness, mental retardation and related conditions, hearing therapy for communication delay, and therapy for perceptual disorders, except limited coverage for learning disabilities or Developmental Delay as specifically listed in the Benefits provision of this Certificate.
B. Massage therapy or aquatic therapy, except the coverage that is specifically provided in the Benefits section of this certificate;
C. Hypnosis or acupuncture treatment;
D. Sex therapy;
E. Chelation therapy except in the treatment of heavy metal poisoning;
F. Treatment, services or supplies for holistic or homeopathic medicine or other programs that are not accepted medical practice, as determined by Us, including but not limited to aromatherapy, herbal medicine, naturopathy; and reflexology;
G. Biofeedback

TRANSPLANTS

A. Transplants considered by Us to be Experimental, Investigational or unproven.
B. Animal to human solid transplant except as determined by Us.
C. Artificial mechanical devices designed to replace human organs.

D. Pancreas transplant alone (PTA), unless satisfying criteria as determined by Us or preceded by renal transplant/PAK (Pancreas transplant after kidney transplant).
E. Islet cell transplant.
F. Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for a duration of at least 5 years.
G. Living donor transplantation of the intestines and pancreas.
H. Bone marrow transplant (BMT), autologous bone marrow transplant (ABMT), or peripheral blood stem cell transplant (PBSCT) for:
    1. Testicular cancer, except germ cell cancer;
    2. Breast cancer which is resistant to chemotherapy or when done in the initial course of treatment;
    3. Brain tumors of any kind (including but not limited to gliomas, astrocytomas, and medulloblastomas);
    4. Multiple myeloma when resistant to chemotherapy;
    5. Lung cancers;
    6. Ovarian, uterine and cervical cancer;
    7. Malignant melanoma and other skin cancer;
    8. Cancer of the genitourinary tract including but not limited to prostate and bladder cancer;
    9. Peripheral neuroepithelioma;
    10. AIDS;
    11. Gastrointestinal tract cancer including esophagus, gastric, colon;
    12. Cancer of the pancreas;
    13. Patient's with brain metastases;
    14. Head and neck cancer;
    15. Sickle cell anemia;
    16. Immune thrombocytopenic purpura;
    17. Multiple sclerosis;
    18. Non-Hodgkins lymphoma with low grade histologies;
    19. Non-Hodgkins lymphoma of intermediate/high grade histologies with primary refractory disease;
    20. Hairy cell leukemia;
    21. Acute lymphocytic leukemia and acute myeloid leukemia with primary refractive disease;
    22. Acute lymphocytic leukemia in first complete remission.
I. Expenses related to the purchase of any organ.
J. Expenses excluded by the General Exclusions.
K. Organ transplants which are not listed as Approved Transplant Services.

VISION SERVICES

A. The following vision services and supplies unless provided elsewhere in this Plan:
    1. Vision therapy;
    2. Orthoptics (eye exercise);
    3. The purchase or fitting of eye glasses or contact lenses; and
    4. Correction of visual acuity or refractive errors by any means.

WEIGHT CONTROL/NUTRITION

A. Utilization of services, supplies, equipment or facilities in connection with weight control or reduction, whether or not prescribed by a Practitioner or associated with an Illness, including, but not limited to:
    1. Gastric or intestinal bypasses;
    2. Gastric balloons;
    3. Stomach stapling;
    4. Wiring of the jaw;
    5. Liposuction;
    6. Drugs;
    7. Weight loss programs unless benefits are provided elsewhere in this Plan;
    8. Physical fitness or exercise programs or equipment unless benefits are provided elsewhere in this Plan.
B. Nutrition counseling services, except the coverage that is specifically provided in the Benefits section of this certificate.

EFFECTIVE DATE PROVISIONS

ELIGIBILITY

Eligibility begins on the date You and Your Dependents meet all eligibility criteria as specified in the Employer Application. Eligibility criteria includes number of hours worked per week, completion of a Waiting Period (if any), etc.

An Employee whose coverage is terminated by reason of military service under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time, and who is reemployed by the Employer within the time allowed by law, will be immediately eligible to participate in the Plan on the date he/she returns to employment as an Eligible Employee. The individual must submit a completed enrollment form to Us within 30 days of his/her return to employment. No new waiting period will apply.

ENROLLMENT AND EFFECTIVE DATE OF YOUR COVERAGE

You must be enrolled within 30 days of becoming eligible by completing an Enrollment/Change Form available from your employer.

Your effective date of coverage will be based on the following:

A. If the Enrollment/Change Form is received by Us prior to Your eligibility date, You are covered on the date You are initially eligible.
B. If the Enrollment/Change Form is received by Us after Your initial eligibility date but within 31 days from Your initial eligibility date, You are covered on the first of the month following receipt of the Enrollment/Change Form or on the date specified on the Enrollment/Change Form.
C. If the Enrollment/Change Form is received by Us after 31 days from the initial eligibility date and the Special Enrollment Provision is not applicable, You are considered a Late Enrollee.

If You are not Actively At Work for reasons other than Illness or Injury on the date Your coverage would begin, Your health coverage will not be effective until the day You return to Active Work.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent will be covered under the Plan when We receive the written application and payment of premium for the Dependent. He or she will become covered on the later of:

A. The date Your coverage with Us begins if You have eligible Dependents who may be covered on that date;
B. The first of the month coinciding with or following the date You acquire Your Dependent if You requested coverage within 31 days after that date;
C. The date of Your marriage for any Dependent (spouse or stepchild) acquired on that date;
D. The date of birth of a child born to an Employee; or
E. The date a child is Placed for Adoption or legal guardianship or the date that a court issues a final order granting adoption of the child to You, whichever occurs first; or
F. The date of birth of a child born to Your covered Dependent child who is under the age of 18. Coverage terminates for the child of a covered Dependent child when the covered Dependent child reaches 18 years of age.

If Your Dependent is enrolling for coverage as a Late Enrollee, Your Dependent's coverage will become effective the first day of the month coinciding with or following the date the Dependent enrolls.

NEWBORN INFANT REQUIREMENTS

Your newborn Child is covered from the date of birth. Coverage shall continue for 60 days. If additional premium is required to cover the Child, then during the 60-day period You must make written request for coverage and pay the required premium. If you do not make the request and pay the premium, then coverage for the newborn Child will not continue beyond the 60 day period, unless within 1 year after the birth of such newborn Child provided You pay all of the required past due premium. The premium will include interest at a rate of 5-1/2%.

Coverage for Your newborn Child under this provision, includes treatment for congenital defects and birth abnormalities on the same basis as treatment for any other Illness or Injury.

ADOPTED CHILD REQUIREMENTS

An adopted Child or a Child Placed For Adoption shall become covered under this Plan subject to the following:

A. You must make written request to Us and pay a premium, if any, within 60 days after the earlier of the following:
   2. The date a court makes final order granting adoption; or
   3. The date the Child is Placed For Adoption with You.
B. The coverage shall become effective on the earlier date of:
   1. The court order; or
   2. The Child is Placed for Adoption.
C. Benefits shall be payable for charges incurred after such Child's effective date of coverage under this Plan for the necessary care and treatment of medical conditions existing prior to the date of placement or adoption for such Child.
D. If the adoption is not finalized after the Child is Placed For Adoption, the coverage shall terminate when the Child's adoptive placement with You terminates.

DECLINING ENROLLMENT PROVISION

If You decline coverage for yourself or Your Dependents because of other health coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, provided that You request enrollment within 31 days after Your other coverage ends.

In addition, if You have a new Dependent as a result of marriage, birth, adoption or Placement for Adoption, You may be able to enroll yourself and Your dependents, provided that You request enrollment within 30 days after marriage, birth, adoption or Placement for Adoption. See Special Enrollment Provision below.

LOSS OF OTHER HEALTH COVERAGE

If You or Your Dependents were not enrolled, You or Your Dependents may enroll for health coverage under this Plan, but only if the following conditions are met:

A. The person was covered under a health plan at the time coverage under this Plan was first offered to the person;
B. The person stated in writing that the reason for declining coverage was due to coverage under another health plan;
C. The person requests enrollment under this Plan no later than 31 days after the date the other coverage ended. This coverage will become effective on the day after the other coverage ended or on an earlier date, as agreed to by Us.

SPECIAL ENROLLMENT PROVISION

If You or Your Dependents:

A. Did not have other health coverage as outlined above under Loss of Health Coverage;
B. Are otherwise eligible under this Plan;
C. Failed to enroll when first eligible; and
D. A person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption;

We will provide for a special enrollment period as described below:

A. You and Your Dependents who are not already enrolled, may enroll for coverage under this Plan during a special enrollment period. This special enrollment period is 31 days, and begins on the date of marriage, birth, adoption or Placement for Adoption.
B. If You request to enroll during this special enrollment period, the coverage will become effective:
   1. In the case of marriage, on the date of the marriage; or
   2. In the case of a Dependent's birth, on the date of such birth; or
   3. In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption.

LATE ENROLLMENT

Persons who did not enroll when initially eligible for coverage and who are not eligible for a special enrollment period are considered Late Enrollees. If You are enrolling for coverage as a Late Enrollee, Your coverage will become effective the first day of the month coinciding with or following the date You enroll. The Pre-Existing Condition Exclusion Provision of this Plan will apply.

PRE-EXISTING CONDITIONS EXCLUSIONS PROVISION

This Plan has an exclusion for Pre-Existing Conditions. Benefits will not be paid for Covered Expenses for a Pre-Existing Condition until the day after a Covered Person has completed 12 consecutive months (18 consecutive months if a Late Enrollee) from the Enrollment Date. Benefits will then be payable for Covered Expenses incurred for a Pre-Existing Condition after such 12 or 18 consecutive month period.

EXCEPTIONS TO PRE-EXISTING CONDITION EXCLUSION

The Pre-Existing Condition exclusion does not apply to:

A. Any person who, on the Enrollment Date, had 12 consecutive months (18 consecutive months if a Late Enrollee) of Creditable Coverage;
B. Pregnancy, including complications;
C. A Dependent Child, who, as of the last day of the 31 day period beginning with the date of birth, had any Creditable Coverage and did not have a Significant Break in Coverage;
D. An adopted Dependent child or Dependent child Placed for Adoption under the age of 18 who, as of the last day of the 31 day period beginning on the date of adoption or Placement for Adoption, had any Creditable Coverage and did not have a Significant Break in Coverage. However, the Pre-Existing Conditions exclusion will apply to coverage such Child may have had before such adoption or Placement for Adoption; or
E. Genetic information, in the absence of a diagnosis of an Illness related to such information.

REDUCTION OF PRE-EXISTING CONDITIONS EXCLUSION TIME PERIOD

If on the Enrollment Date a Covered Person has less than 12 consecutive months (18 consecutive months for a Late Enrollee) of Creditable Coverage, We will credit the time the Covered Person had Creditable Coverage in determining whether the Pre-Existing Conditions exclusion applies.

If a Covered Person has a Significant Break in Coverage, any days of Creditable Coverage that occur before the Significant Break in Coverage will not be counted by Us to reduce the Pre-Existing Conditions exclusion time period. Waiting Periods will not count as a Significant Break in Coverage.

REINSTATEMENT OF ALL COVERAGES

If Your coverage ends due to termination of employment, leave of absence or lay-off and You later return to Active Work, You must meet all requirements of a new employee. This requirement does not apply if Your coverage ends due to leave of absence or lay-off and you return to Active Work within six months from the day Your leave of absence or lay-off began.

CHANGES TO ENROLLMENT FORM

Changes to Your original Employee Application Form must be made by contacting Us and/or by completing an Enrollment/Change Form which is available through Your employer.

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

The **Member Rights and Responsibilities** listed below set the framework for cooperation among Covered Persons, Practitioners and Us.

YOUR RIGHTS AS A HEALTH PLAN MEMBER

You have the right to receive quality health care that's friendly and timely.

You have the right to be treated with respect and recognition of Your dignity and right to privacy.

You have the right to receive all medically necessary covered services when Your health care providers feel they are needed.

You have the right to a candid discussion of appropriate or medically necessary treatment options for Your conditions, regardless of cost or benefit coverage.

You have the right to refuse treatment.

You have the right to participate with practitioners in making decisions about Your health care.

You have the right to all information contained in Your medical records.

You have the right to receive information about Us, Our services, and Our network of health care practitioners and providers and Your rights and responsibilities.

You have the right to make a list of instructions about Your health treatments (called a living will) and to name the person who can make health care decisions for You.

You have the right to have Your medical and financial records kept private.

You have the right to voice complaints or appeals about Us or the care We provide.

You have the right to have a resource at the health plan, clinic, or governing agency that You can contact with any concerns about services and to receive a prompt and fair review of Your complaint.

You have the right to make recommendations regarding the member rights and responsibilities policies.

YOUR RESPONSIBILITIES AS A HEALTH PLAN MEMBER

You have the responsibility to select a Primary Care Practitioner and communicate with him or her in order to develop a patient-physician relationship based on trust, respect and cooperation.

You have the responsibility to know Your health plan benefits and requirements.

You have the responsibility to coordinate all non-life-threatening, in-network care through Your Primary Care Practitioner.

You have the responsibility to review Your insurance information upon enrollment and ask questions to verify that You understand the procedures and explanations that are given.

You have the responsibility to supply information (to the extent possible) that We and Our practitioners and providers need in order to provide care.

You have the responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

You have the responsibility to follow the treatment plan and instructions for care that have been agreed on with Your practitioners.

You have the responsibility to give proof of coverage each time You receive services and to update Your clinic with any personal changes.

You have the responsibility to pay copays when You receive services and to promptly pay deductibles, coinsurance, and charges for services not covered.

You have the responsibility to keep appointments for care or to give early notice if You need to cancel.

The WPS Health Plan, Inc. **Quality Management Committee** evaluates and monitors key aspects of services and health care provided to members. The medical director directs the Quality Management Committee. Various committees consisting of Participating Providers and WPS Health Plan, Inc. leadership guide, direct, and evaluate quality initiatives. Participating Providers are evaluated using nationally accepted criteria prior to joining the network and every three years thereafter.

Health management studies and projects are completed to increase rates of preventive services and improve management of acute and chronic diseases. The Quality Management Committee is responsible for directing the process of improvement efforts.

COORDINATION OF BENEFITS

Read this section with care. It applies to all health provisions of this Plan that pay benefits for Expenses Incurred, except the Prescription Drug Benefit if it is contained in this Plan. The purpose of this Plan is to help You pay for Covered Expenses, but not to result in total benefits greater than the Covered Expenses incurred.

This Coordination of Benefits (COB) provision applies when a Covered Person has health 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 pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total Allowable Expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment:
   1. Plan includes: group insurance, Closed Panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
   2. Plan does not include: individual or family insurance; Closed Panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.
   3. Each contract for coverage under 1. or 2. is a separate Plan. If a Plan has two parts and COB rules apply to only one of the two, each of the parts is treated as a separate Plan.

B. The Order of Benefit Determination Rules determine whether this Plan is a Primary Plan or Secondary Plan when compared to another Plan covering the Covered Person. When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

C. Allowable Expense means a health care service or expense, including Deductibles and Copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services, (for example an 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. The following are examples of expenses or services that are not Allowable Expenses:
   1. If a Covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the Covered Person's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of this Plan’s Usual and Customary fees for a specific benefit is not an Allowable Expense.
   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of this Plan’s negotiated fees is not an Allowable Expense.
   4. If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, an amount in excess of this Plan’s payment arrangement is not an Allowable Expense.
   5. If a person is covered by Medicare, an amount in excess of the Medicare allowable fee is not an Allowable Expense.

6. The amount a benefit is reduced by the Primary Plan because a Covered Person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, Authorization of admissions, and preferred provider arrangements.

D. Claim Determination Period means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under this Plan.

E. Closed Panel Plan is a Plan that provides health benefits to Covered 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 for services provided by other providers, except in cases of Emergency or referral by a panel member.

F. 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 one half of the Calendar Year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a Coordination Of Benefits provision is always Primary.

C. 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.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

1. Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent is Primary and the Plan that covers the person as a Dependent is Secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and Primary to the Plan covering the person as other than a Dependent (e.g., a Retired Employee); then the order of benefits between the two plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is Secondary and the other Plan is Primary.

2. Child Covered Under More Than One Plan

a. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

i. The parents are married;

ii. The parents are not separated (whether or not they have been married); or

iii. 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 longer 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, 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:

i. The Plan of the Custodial Parent;

ii. The Plan of the spouse of the Custodial Parent;

iii. The Plan of the non-Custodial Parent; and then

iv. The Plan of the spouse of the non-Custodial Parent.

3. Active or Inactive Employee. The Plan that covers a person as an employee who is neither laid off nor retired, is Primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, or subscriber, or retiree (or as that

person's Dependent) is Primary; and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is Primary.
6. If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this Provision. In addition, this Plan will not pay more than it would have paid had it been Primary.

EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is Secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100 percent of the total Allowable Expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Plan will:

A. Determine its obligation to pay or provide benefits under its contract;
B. Determine whether a benefit reserve has been recorded for the Covered Person; and
C. Determine whether there are any unpaid Allowable Expenses during that Claims Determination Period.

If there is a benefit reserve, the Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the remainder of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim Determination Period.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying those 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.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term Payment Made includes providing benefits in the form of services, in which case Payment Made means 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 We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

RECOVERY RIGHTS

SUBROGATION AND REIMBURSEMENT

We have the right to subrogate against a third party or seek reimbursement from You for the full value of the medical expenses necessarily incurred by You, and related to an Illness or Injury caused by a third party. As used in this section "full value" is the reasonable and necessary amount of charges or payments related to an Injury. In providing benefits, We may obtain discounts from healthcare providers, compensate providers on a capitated basis or enter other arrangements under which We pay less than the reasonable value of the services provided to You. Regardless of any such arrangement, when You receive a benefit under the Plan for an Illness or Injury, We are subrogated to Your right to recover the full reasonable value of the services provided for Your Illness or Injury, even if that reasonable value exceeds the amount paid by Us.

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

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

A. Sign and deliver all necessary papers We reasonably request to protect or enforce Our rights;
B. Do whatever else is necessary to protect or allow Us to enforce Our rights including joining us as a party as we may request, when You have commenced a legal action to recover for a personal Injury; and
C. Shall not do anything before or after Our payment that would prejudice Our rights.

Our right to subrogate shall not apply unless You have been made whole for loss of payments which You or any other person or organization is entitled to on account of Illness or Injury. Our claim for Subrogation or Reimbursement will be reduced by an amount representing comparative negligence reasonably attributable to You, and You agree that you have been made whole by any settlement where Your claim has been reduced because of Your contributory negligence. You also agree that You have been made whole if You receive a settlement for less than the Third Party insurance company's policy limits. If a dispute arises over the question of whether or not You have been made whole, We reserve the right to seek a judicial determination of whether You have been made whole.

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

WORKERS’ COMPENSATION

This certificate is not issued in lieu of nor does it affect any requirements for coverage by Workers' Compensation. Items or services for Injuries or Illnesses which are job, employment or work related, or for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, are excluded from coverage by Us. However, if benefits are paid by Us and it is determined that You are eligible to receive Workers' Compensation for the same incident, We have the right to recover any benefits provided. As a condition of receiving benefits on a contested work or occupational claim, You will consent to reimburse Us when entering into any settlement and compromise agreement, or at any Workers' Compensation Division Hearing. We reserve the right to recover against You even though:

A. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
B. No final determination is made that the Injury or Illness was sustained in the course of, or resulted from employment;
C. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You will not enter into a compromise or hold harmless agreement relating to any work-related claims paid by Us, whether or not such claims are disputed by the Workers' Compensation insurer, without Our express written agreement.

EXCESS COVERAGE LIMITATION

Services, supplies or other care for Injury or Illness for which there are expenses covered by non-group individual traditional automobile (fault) insurance (except individual health insurance policies) or premises medical expense coverage, unless the other coverage is expressly excess to this certificate. If benefits subject to this provision are paid, We shall exercise Our rights of subrogation or reimbursement as provided in this section.

INDIVIDUAL TERMINATION PROVISION

YOUR COVERAGE

Your coverage under this Plan will end on the earliest of:

A. The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due;
B. The date Your total benefits reach the amount of the lifetime benefit maximum under the Plan;
C. The date this Plan is canceled;
D. The date coverage for Your benefit class is canceled;
E. The day of the month in which You or Your employer tells Us to cancel Your coverage if You are voluntarily canceling it while remaining eligible, or You are no longer Actively at Work or a member of a covered class. Please contact your employer to determine which date Your employer has elected. However, Your health coverage may be continued as follows:
    1. If disabled, Your health coverage will continue until the Plan Holder tells Us to cancel Your coverage, but no longer than 3 months from the date Your coverage would otherwise end;
    2. If granted a leave of absence, Your coverage will continue until the Plan Holder tells us to cancel Your coverage, but no longer than 2 months;
F. The day of the month in which You retire unless this Plan provides coverage for Retired Employees.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

A. The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due;
B. The date Your coverage ends;
C. The day of the month in which Your Dependent no longer meets the definition of a Dependent as outlined in the Definitions section;
D. The date the Plan Holder tells Us to cancel all Dependent coverage; or
E. The day of the month in which You or the Plan Holder tells Us to cancel Your Dependent coverage if You are voluntarily canceling it while remaining eligible.

EXTENSION OF BENEFITS

If You or Your Dependent are receiving Inpatient care on the day coverage otherwise ends, coverage will continue until the earliest of:

A. The day You or Your Dependent are not Inpatient;
B. The date on which 90 consecutive days have passed since You or Your Dependent's coverage under this Plan ended or Your or Your Dependent lost eligibility; or
C. A period of time equal to the length of time covered under this Plan; or
D. You or Your Dependent exhaust the maximum benefit limits under this Plan while an inpatient.

Benefits are payable only for Covered Expenses incurred due to the Illness or Injury that caused the Inpatient stay.

DISENROLLMENT FROM THE PLAN

Disenrollment means that You or Your Dependent's coverage under the Plan is revoked. We can disenroll You or Your Dependent only for the reasons listed below:

A. Required premiums are not paid by the end of the grace period; or
B. You or Your Dependent commit acts of physical or verbal abuse that pose a threat to Our providers or to other Covered Persons; or
C. You allow a non-Covered Person to use the Member's ID card to obtain services; or
D. You have provided fraudulent information in applying for coverage; or
E. You are unable to establish or maintain a satisfactory relationship with Your Primary Care Physician. (If a Covered Person refuses to follow the recommend treatment of his/her Primary Care Physician, this may constitute an unsatisfactory physician-patient relationship.) Disenrollment for this reason shall be permitted only when We can demonstrate that We provided You an opportunity to select another participating Primary Care Physician, made a reasonable effort to assist in establishing a satisfactory physician-patient relationship, and properly communicated Grievance procedures to You.

If We disenroll a Covered Person for any reason other than the required premiums were not made,

We will make arrangements to provide similar alternative coverage to the disenrolled Covered Person. Coverage shall continue until the Covered Person finds other health care coverage or until the next opportunity for the Covered Person to change insurers, whichever comes first.

GROUP TERMINATION PROVISION

In the event this Plan is terminated in its entirety according to the termination provisions in the Plan Holders Master Contract, the Extension of Benefits explained in the Individual Termination Provision is deleted and replaced with the following:

EXTENSION OF BENEFITS

If You or Your Dependents are Totally Disabled on the day this Plan terminates, coverage will continue until the earliest of the following:

A. The date You or Your Dependent are not Totally Disabled, as determined by Us; or
B. The end of 12 consecutive months immediately following the date of termination of coverage; or
C. The date the maximum benefit available is exhausted; or
D. The date coverage is provided under another group medical plan, other than temporary coverage, for the condition or conditions causing the Total Disability

Benefits are payable only for Covered Expenses incurred due to the Illness or Injury that caused the Total Disability.

If You were covered (including benefit extension) under the Plan Holder's prior plan and it was in effect immediately prior to the date this Plan becomes effective and You would not be eligible for coverage under this Plan because of the Actively At Work requirement, You shall be eligible for coverage under this Plan subject to the following:

A. The level of benefits provided by this Plan shall be at the level provided by the prior plan reduced by any benefits actually paid by the prior plan.
B. The level of reduced benefits shall be provided by this Plan until at least the earliest of the following dates:
    1. The date You return to active work with the Plan Holder;
    2. The date Your coverage would terminate in accordance with this Plan's provisions;
    3. If You were Totally Disabled at the time the prior Plan was discontinued, the last day of any period of extension provided by that prior plan or if the prior plan did not provide for such a period of extension then the date shall be 12 months from the date the prior plan was discontinued.

In the event a Covered Person was covered under the Plan Holder's prior plan and it was in effect immediately prior to the date this Plan becomes effective and the Covered Person was not Totally Disabled on the date of discontinuance of the prior plan and would not be entitled to payment under this Plan because of this Plan's Pre-Existing Conditions Exclusion, such Covered Person shall be entitled to payment under this Plan subject to the following:

The benefit level that applies to Pre-Existing Conditions of persons who become covered under this provision during the time the Pre-Existing Condition Exclusion applies under this Plan shall be the lesser of:

A. The benefits of this Plan determined without applying the Pre-Existing Conditions Exclusion; or
B. The benefits of the prior plan determined after applying such plan's limitations.

Any Deductibles or Waiting Periods provided by this Plan shall be reduced by a satisfaction or partial satisfaction of the same or similar provisions of the prior plan providing similar benefits. In the case of Deductible provisions, the reduction shall apply for the same or overlapping Illness and shall be given for expenses actually incurred and applied against the Deductible provisions of the prior plan during the 90 days preceding the effective date of this Plan, but only to the extent these expenses are recognized under the terms of this Plan and are subject to a similar Deductible provision.

Total Disability means for an Employee or his or employed covered spouse, that the person is at all times prevented from engaging in any job or occupation for wage or profit. For a covered spouse who is not employed and a covered Dependent child, Total Disability means a disability preventing the person from engaging in substantially all of the usual and customary activities of a person in good health and of the same age and sex. Total Disability is determined by Us based upon medical opinion and other appropriate resources.

FEDERAL CONTINUATION OF COVERAGE PROVISION

THE FOLLOWING IS A SUMMARY OF THE FEDERAL HEALTH CONTINUATION REQUIREMENTS UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA). THIS SUMMARY IS NOT INTENDED TO SATISFY THE NOTICE REQUIREMENTS OF FEDERAL LAW.

COBRA continuation coverage is a continuation of Your coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary."

If Your employer has 20 or more employees, the following provisions are applicable to Your Plan. Your employer will provide You with further information if the specified events occur.

Qualified Beneficiary means someone who will lose coverage under the Plan because of a Qualifying Event. Depending on the type of Qualifying Event, You, Your spouse, and Dependent Children may be Qualified Beneficiaries.

Qualified Beneficiary includes any Child born to or Placed for Adoption with You during the continuation period. You must notify Us of the birth or adoption, submit an Enrollment Change form, and pay additional premium, if any.

Qualifying Event means certain types of events that would cause a Covered Person to lose healthcare coverage. The type of Qualifying Event will determine who the Qualified Beneficiaries are and the required amount of time the Plan Holder must offer the healthcare coverage to them under COBRA.

A. Qualifying Events for a covered Employee:

1. Termination of employment (for any reason other than gross misconduct); or
2. Reduction in hours of employment.

This includes an absence from employment for service in the Armed Forces.

B. Qualifying Events for a Spouse:

1. Your death;
2. A termination of Your employment (for any reason other than gross misconduct) or reduction in hours of employment;
3. Your divorce or legal separation; or
4. Your entitlement to Medicare (under Part A, Part B or both).

C. Qualifying Events for a Dependent Child:

1. Your death if You are the parent through whom the Child receives coverage;
2. Your termination of employment (for any reason other than gross misconduct) or reduction in hours of employment;
3. Your divorce or legal separation from the Child's other parent;
4. Your entitlement to Medicare (under Part A, Part B or both) if You are the parent through whom the Child receives coverage; or
5. The Child ceases to be a "Dependent Child" under the terms of the Plan.

RESPONSIBILITY FOR NOTIFICATION

A. When the Qualifying Event is the end of employment or reduction of hours of employment, Your death, or Your becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Holder must notify Us of the Qualifying Event within 30 days of any of these events.

B. For the other Qualifying Events (Your divorce or legal separation or a Dependent Child's losing eligibility for coverage as a Dependent Child), You must notify the Plan Holder within 60 days after the Qualifying Event occurs.

ELECTION OF CONTINUATION COVERAGE

Qualified Beneficiaries have at least sixty (60) days from the later of the following dates to elect continuation coverage: (1) the date coverage would be lost because of one of the Qualifying Events or (2) the date the Qualified Beneficiary receives notice of Your right to elect continuation coverage. If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost.

You or Your spouse, if covered by the Plan, may elect continuation coverage on behalf of other family members entitled to continuation coverage. However, each person entitled to continuation coverage has an independent right to elect continuation coverage. Your spouse or Dependent Child may elect continuation coverage even if You do not elect continuation coverage.

A person does not have to demonstrate insurability to elect continuation coverage.

If continuation coverage is not elected in the timeframe described above, a Qualified Beneficiary will lose his/her right to elect continuation coverage and group healthcare coverage will end.

TYPE OF COVERAGE

Continuation coverage is the same coverage that this Plan provides to other Covered Persons under the Plan who are not receiving continuation coverage. Each Qualified Beneficiary who elects continuation coverage will have the same rights and benefits under this Plan as other Covered Persons under the Plan.

COST OF COVERAGE

Each Qualified Beneficiary may be required to pay the entire cost of continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated Covered Person who is not receiving continuation coverage.

PAYMENT FOR CONTINUATION COVERAGE

A. A Qualified Beneficiary must make his/her first payment for continuation coverage within 45 days after the date of his/her election. If the Qualified Beneficiary does not make his/her first payment for continuation coverage within that 45 days, he/she will lose all continuation coverage rights under the Plan. The first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated up to the time of the first payment.

B. After a Qualified Beneficiary makes his/her first payment for continuation coverage, he/she will be required to pay for continuation coverage for each subsequent month of coverage.

C. After the first payment, a Qualified Beneficiary will be given a grace period of 30 days to make each subsequent payment. Continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If a Qualified Beneficiary fails to make a payment before the end of the grace period for that payment, he/she will lose all rights to continuation coverage under the Plan.

DURATION OF COVERAGE

COBRA continuation coverage is a temporary continuation of coverage.

A. When the Qualifying Event is Your death, Your becoming entitled to Medicare (under Part A, Part B; or both), Your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

B. When the Qualifying Event is Your end of employment or reduction of hours of employment, and You became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than You lasts until 36 months after the date of Medicare entitlement.

C. When the Qualifying Event is Your end of employment or reduction of hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. Disability Extension of 18-month Period of Continuation Coverage

   If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage

and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Holder is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

2. Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If another Qualifying Event occurs while receiving COBRA continuation coverage, Your spouse and Dependent Children can get additional months of COBRA continuation coverage; up to a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Holder.

This extension may be available to Your spouse and any Dependent Children receiving continuation coverage if You die, become entitled to Medicare (under Part A, Part B, or both), or get divorced or legally separated.

The extension is also available to a Dependent Child when that child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage had the first Qualifying Event not occurred.

In all of these cases, the Plan Holder must be notified of the second Qualifying Event within 60 days of the second Qualifying Event.

EARLIER TERMINATION OF COVERAGE

Continuation coverage will be terminated before the end of the maximum period if:

A. Any required premium is not paid on time;

B. A Qualified Beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the Qualified Beneficiary;

C. You become entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage; or

D. The Plan Holder ceases to provide any group health plan for its Employees.

Continuation coverage may also be terminated for any reason We would terminate coverage of a Covered Person not receiving continuation coverage (such as fraud).

If a Qualified Beneficiary was validly covered under the continuation provision of the Plan Holder's prior plan that this Plan replaced, such person shall be eligible for coverage under this Plan. The number of months in which the coverage was in force under such prior plan's continuation provision shall be used to satisfy the continuation provision of this Plan.

USERRA

If You leave Your job to perform military service, You have the right to elect to continue Your existing employer-based health plan coverage for You and Your Dependents for up to 24 months while in the military.

If You don't elect to continue coverage during Your military service, You have the right to be reinstated in Your employer's health plan when You are reemployed.

STATE CONTINUATION LAWS

Please review the Wisconsin Continuation of Coverage and Conversion Privilege provision to see if You are eligible for continuation under state law. Under some circumstances, continuation under state law may be more advantageous to You than continuation under federal law. You may be eligible for continuation under state law even if You are not eligible for continuation under federal law. Any time periods satisfied under state continuation provisions will be used to satisfy the federal continuation provisions. Consequently, any time periods satisfied under federal continuation provisions will be used to satisfy the state continuation provisions.

In the event:

A. The coverage of a spouse would terminate because of divorce or annulment;
B. The coverage of an Employee would terminate for reasons other than discharge for misconduct in connection with employment; or
C. The coverage of a spouse or any other Dependent would terminate because of the death of the Employee;

and, if a Covered Person was covered under this Plan during the entire three month period immediately before the date the coverage terminates, a Covered Person may elect to continue Hospital and medical coverage under this Plan in accordance with the Continuation of Coverage and Conversion Privilege outlined below, subject to the following provisions:

If the coverage would terminate as outlined above, the Plan Holder shall provide written notice of the right to continue group coverage or convert to an individual policy, and the premium payable for either continued or converted coverage. Such notice shall include the manner, place and time in which premium shall be paid. This notice shall be given not more than five days after the date in which the coverage would otherwise terminate.

CONTINUATION OF COVERAGE

If the Covered Person elects to continue group coverage and submits the premium required to the Plan Holder within 30 days after receiving the notice described above, the coverage shall continue without interruption from the date coverage would otherwise terminate. Such continuation shall terminate when any one of the following events first occurs:

A. The end of 18 months from the date coverage would otherwise terminate;
B. The Covered Person establishes residence outside the State of Wisconsin;
C. The Covered Person fails to make the required premium contribution when due;
D. In the case of a former spouse, the Employee through whom the former spouse originally obtained the coverage is no longer eligible for coverage under this Plan; and
E. The Covered Person is or becomes eligible for similar coverage under another group plan.

Dependent coverage cannot be continued without continuing Employee coverage except in the case of the death of the Employee.

The coverage of a Covered Person who is eligible for Continuation of Coverage under this Plan shall continue until such Covered Person is notified of the right to elect Continuation of Coverage or the Conversion Privilege if the premium for coverage continues to be paid.

If an Employee or Dependent was validly covered under the continuation provision of the Plan Holder's prior plan that this Plan replaced, such Employee or Dependent shall be eligible for coverage under this Plan. The number of months in which the coverage was in force under such prior plan's continuation provision shall be used to satisfy the 18-month continuation provision of this Plan.

The Covered Person shall have the right to convert to an individual policy as provided below at any time during or at the end of the 18-month continuation period. This right shall not apply to a termination in accordance with items C. and E. above.

CONVERSION PRIVILEGE

If the Covered Person is entitled to the Conversion Privilege, such Covered Person will be eligible to have issued an individual conversion coverage policy subject to the following provisions:

A. Written application and payment of the first premium for such policy must be made within 31 days after notice of termination.
B. The premium for such policy will be based on the current rates applicable to the form and amount of the individual conversion policy.
C. Such policy will be effective on the day following the termination of coverage under this Plan.
D. Such policy may cover, in addition to the covered employee, any Dependents who were also covered under this Plan on the day before the termination of coverage under this Plan.
E. This policy will be issued by Us, Our affiliated companies, or company We designate to issue such policies.

FEDERAL FAMILY MEDICAL LEAVE OF ABSENCE PROVISION

If an Employee is on a family or medical leave of absence, We will continue coverage under this Plan in accordance with the Plan Holder's Human Resource policy on family and medical leaves of absence, as if the employee was Actively at Work if the following conditions are met:

A. Premium is paid; and
B. The Employee has written approved leave from the Plan Holder.

Coverage will be continued for up to the greater of:

A. The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or
B. The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the employee becomes Actively at Work:

A. No new Waiting Period will apply; and
B. The Pre-Existing Conditions Exclusion, if any, shall not apply.

If a court orders You to provide coverage for a Dependent Child's health care expenses, and You are eligible for family coverage under the Plan, the Child will be enrolled without regard to any enrollment period restrictions upon application by You, the Child's other parent, the Department of Health and Family Services (DHFS), or county designees.

The effective date will be the date specified on the court decree or order.

Coverage shall be provided under this Plan until:

A. The Child is no longer a Dependent as defined in this Plan;
B. We receive satisfactory written evidence that the court order is no longer in effect; or
C. The Child has coverage under another group policy or individual policy that provides comparable health services.

We may use the same factors to determine eligibility and premium rates for a Child who is the subject of a medical child support order as We do for other children.

If We provide coverage under this Plan for a Child of an Employee who is not the custodial parent, We will do all of the following:

A. Provide the custodial parent with information relating to the child's enrollment;
B. Permit the custodial parent, a health care provider, or the DHFS to submit claims for Covered Expenses without the Employee's approval.
C. Pay claims directly to the health care provider, the custodial parent or the DHFS.

A custodial parent is a parent who has been awarded physical placement of the Child for more than 50% of the time.

Qualified Medical Child Support Orders are subject to the following:

A. The Medical Child Support Order must be qualified as determined by the Plan Holder.
B. A copy of the Qualified Medical Child Support Order must be submitted to us with the request to cover such Child on forms approved by Us.

GRIEVANCE AND INDEPENDENT REVIEW PROVISION

This Grievance procedure will be used to resolve all Grievances regarding plan administration or benefit denials. All Grievances, whether directed to Us or to a Participating Provider, will be reviewed according to the procedure outlined below.

This section includes the appeal rights and the Grievance procedure for Covered Persons of Plans that are governed by the Employee Retirement Income Security Act of 1974 (ERISA). Members of ERISA plans have the right to file a civil action under Section 502 (a) of ERISA if a health plan fails to establish or follow claims procedures, or after all appeals outlined in this section have been completed.

Grievance means any dissatisfaction with the administration, claims practices, or provision of services by the Plan that is expressed in writing to Us by, or on behalf of, a Covered Person.

Grievance Review Panel means a group consisting of Our representative, a plan medical representative and a Covered Person.

ACKNOWLEDGEMENT OF GRIEVANCE

We will acknowledge receipt of all Grievances within 5 business days of receipt of a Grievance.

GRIEVANCE PROCEDURE

All Grievances will be resolved within 30 calendar days of Our receipt of the Grievance. Such 30-day period may be extended an additional 30 calendar days at Our request. If the Grievance cannot be resolved within the original 30-day period, We will provide written notification to the Covered Person, or the Covered Person's authorized representative, if applicable, that the Grievance has not been resolved, the reason additional time is needed, and when resolution may be expected.

GRIEVANCE REVIEW PANEL APPEARANCE

Any Covered Person who files a Grievance will be notified of their right to appear in person before the Grievance Review Panel. The Covered Person may present written or oral information and ask any questions relating to the Grievance. We will send the Covered Person written notice of the time and place the Covered Person may appear before the Grievance Review Panel at least seven calendar days prior to the appearance date.

CLAIM DENIALS

If a claim or benefit is denied, in whole or in part, the Covered Person will receive written notice from Us of such denial and the reasons for the denial, with reference to pertinent Plan provisions. The notice will also inform the Covered Person of the right to file a Grievance and the procedure to follow. Referral denials will be considered claim denials, and will follow the same notification process.

URGENT CARE, EXPEDITED GRIEVANCE

If We receive a Grievance, either written or oral, pertaining to an urgent care situation, or if an "Expedited Grievance" is required, the Grievance Review Panel will resolve such Grievance within 72 hours of receiving the Grievance.

Expedited Grievance means a grievance where any of the following apply:

The duration of the standard resolution process will result in serious jeopardy to the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function;

In the opinion of a physician with knowledge of the Covered Person's medical condition, the Covered Person is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance; or

A physician with knowledge of the Covered Person's medical condition determines that the Grievance shall be treated as an expedited Grievance.

RECORDS FILE

We will maintain a record of all complaints and Grievances received, and the action taken with respect to such complaints and Grievances. This record of complaints and Grievances will be retained by Us for three years after final notification to the Covered Person of the disposition of the Grievance.

INDEPENDENT REVIEW

In addition to Our internal Grievance procedure, We are required to provide an independent review procedure for review of certain decisions. These decisions include denial of, or refusal to pay for, treatment that We consider to be Experimental (experimental treatment determination), or not Medically Necessary (adverse determination).

Experimental treatment determination means a determination by Us to which all of the following apply:

We have reviewed the proposed treatment.

Based on the information provided, We have determined the treatment is Experimental.

Based on the information provided, We denied the treatment or payment for the treatment.

The amount of the reduction, cost, or expected cost of the denied or terminated treatment or payment exceeds, or will exceed $256 during the course of the treatment.

Adverse determination means a determination by Us to which all of the following apply:

We have reviewed a Covered Person's admission to a health care facility, the availability of care, the continued stay or other treatment for a covered service.

Based on the information provided, the treatment does not meet Our requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness.

Based on the information provided, We reduced, denied or terminated the treatment or payment for the treatment.

The amount of the reduction, cost, or expected cost of the denied or terminated treatment or payment exceeds, or will exceed, $256 during the course of the treatment.

An adverse determination includes the denial of a referral request for health care services from a Non Participating Provider. The right to independent review applies only when the Covered Person feels the Non Participating Provider's clinical expertise is Medically Necessary, and the expertise is not available from a Participating Provider. The treatment must otherwise be covered under this Plan, and the total cost of the denied coverage must exceed $256.

Independent review is available only after the Covered Person has completed the Grievance Procedure, except in the case of an ***expedited*** independent review. If the Covered Person is not satisfied with the outcome of the Grievance, he or she, or their authorized representative, has the right to request and obtain an independent review. The decision of the IRO is binding on Us, and the Covered Person.

Expedited Review

Covered Persons may be entitled to an ***expedited*** independent review. They are not required to complete the Grievance Procedure before requesting an independent review if either of the following situations apply:

If We agree with the Covered Person, or their authorized representative, to proceed directly to independent review; or

The Covered Person needs immediate medical care and the Independent Review Organization determines the requirement to complete the Grievance Procedure before proceeding to independent review would jeopardize the life, health, or ability of the Covered Person to regain maximum function.

To request an expedited independent review, the Covered Person must submit the request to Us and the selected IRO at the same time, with a request to bypass the Grievance Procedure. The IRO will review the request and decide if an immediate review is needed. If the IRO decides that an immediate review is needed, they will review the dispute on an expedited basis. If they decide that the Covered Person's health condition does not require their immediate review of the dispute, they will notify the Covered Person that they must first complete the Grievance Procedure.

Procedure for Independent Review

The Covered Person must select an Independent Review Organization (IRO) from the list of IROs certified by the Wisconsin Office of the Commissioner of Insurance.

The request must be sent to Us at:

Independent Review Coordinator
WPS Health Plan, Inc.
PO Box 11625
Green Bay, WI 54307-1625

Please call member services at (920) 490-6900 or (888) 711-1444 (toll-free) for more information

A request for an independent review must be in writing and must include:

The name, address and phone number of the Covered Person or their representative.

If someone else is filing on behalf of the Covered Person, a statement signed by the Covered Person authorizing such representation;

The name of the selected IRO;

A $25 fee payable to the IRO. This fee will be refunded if the IRO resolves the dispute in favor of the Covered Person.

The Covered Person may also include an explanation of why they believe that the treatment should be covered, along with any additional documentation or information that supports that position.

The Covered Person must request the review within 4 months of the date of the Adverse determination or Experimental treatment determination, or from the date they were notified of the Grievance Review Panel decision.

RIGHT TO FILE COMPLAINT WITH THE COMMISSIONER OF INSURANCE

A Covered Persons may resolve a problem by taking the steps outlined in the Grievance Procedure. They may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE,** a state agency that enforces Wisconsin's insurance laws, and file a complaint. The **OFFICE OF THE COMMISSIONER OF INSURANCE** may be contacted by writing to:

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

Or, call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

Insurance fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of insurance fraud.

As a Covered Person, You must:

A. File accurate claims. If someone else such as Your spouse or another family member files claims on Your behalf, You should review the form before You sign it;
B. Review the explanation of benefits (EOB) form when it is returned to You. Make certain that benefits have been paid correctly based on Your knowledge of the expenses incurred and the services rendered;
C. Never allow another person to seek medical treatment under Your identity. If Your Plan identification card is lost, You should report the loss to Us immediately; and
D. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of Your knowledge.

To maintain the integrity of Your Plan, We encourage You to notify Us whenever a provider:

A. Bills you for services or treatment that You have never received;
B. Asks You to sign a blank claim form; or
C. Asks You to undergo tests that You feel are not needed.

If You are concerned about any of the charges that appear on a bill or explanation of benefits form, or if You know of or suspect any illegal activity, please call our confidential fraud and abuse hotline at 920-617-6300 or 888-711-1444 ext.8300. All calls are strictly confidential.

ENTIRE CONTRACT

The entire contract includes:

A. The group Plan; and
B. The Plan Holder's application; and
C. Your application, if any.

STATEMENTS

We consider statements made by You or the Plan Holder, in the absence of fraud, to be a representation and not a warranty. No statement will be used to void the coverage, reduce benefits, or deny a claim unless:

A. The statement is in writing; and
B. A copy of the Plan Holder's statement is given to the Plan Holder, and
C. A copy of Your statement is given to You.

CHANGES

This Plan may be changed at any time by a written agreement between the Plan Holder and Us with approval by one of Our executive officers.

WRITTEN NOTICE

Written notice given by Us to an authorized representative of the Plan shall be deemed notice to all affected eligible persons and their Dependents, including termination of the group Plan and termination of individual coverage under the group Plan.

CONFORMITY WITH STATE STATUTES

If any part of this Plan does not conform to a statute in the state in which it is issued or delivered, it is amended to conform with the minimum statutes of that state.

PHYSICAL EXAMINATION AND AUTOPSY

We may require that a Covered Person have a physical examination, at Our expense, as often as is necessary to settle a claim. In the case of death, We may require an autopsy unless forbidden by law.

WAIVER

No delay or omission by Us in exercising or enforcing the rights and powers granted to Us in this Plan shall be construed as a waiver of such rights and powers.

FILING CLAIMS

A. How to File a Claim. When a Covered Person has a claim for services received from a Practitioner, he/she should notify Us in writing as soon as is reasonably possible. It is the Covered Person's responsibility to file the claim; however, the Covered Person may arrange for the Practitioner to bill Us. When the Covered Person files the claim, the following information must be filed with Us within 90 days after the date of receipt of service:
   1. Claim forms (including the coding of service, date of service, name of Practitioner, place of service and billed charges) he/she received from the Practitioner at the time of service, and
   2. Proof of payment.

B. Time Limit on Filing Claims. If a Covered Person does not file this information within the required 90 days, benefits will still be paid for Covered Expenses if:
   1. it was not reasonably possible to give proof within such time; and
   2. proof is furnished as soon as possible and in no event, except in the absence of legal capacity of the Covered Person, later than fifteen (15) months after the date of receipt of the service for which the Covered Person is claiming benefits.

C. How to Appeal a Claim Denial. If a claim is denied, the Covered Person may appeal the denial by filing a Grievance. Please refer to the Grievance Provision for a description of a Covered Person's right to appeal a Grievance.

INCONTESTABILITY

The validity of the Plan will not be contested, except for non-payment of premium, after it has been in force for one year from its effective date. The validity of a person's coverage will not be contested after that person's coverage has been in force for two years during his or her lifetime, except for nonpayment of premiums.

LEGAL ACTIONS

No lawsuit or legal action may be filed against Us prior to 60 days after We receive a valid written proof of loss. No such action may begin after three years from the day written proof or loss was required.

WORKERS' COMPENSATION NOT AFFECTED

This Plan does not replace or change any requirement for coverage under Workers' Compensation insurance.