Wausau School District

Employee Health Benefit Plan

SIGNATURE SUMMARY PLAN DESCRIPTION

Effective July 1st, 2021

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

GENERAL INFORMATION ABOUT YOUR PLAN

Your comprehensive Health Care Benefit Plan is provided by Wausau School District for its employees under the terms and conditions of the Administrative Services Agreement on file with Wausau School District.

All medical expenses covered under your Health Care Benefit Plan as described in this plan document are paid for by Wausau School District. This Plan is administered by Aspirus Health Plan, Inc. under a third party administrative agreement between Wausau School District, the Plan sponsor, and Aspirus Health Plan, Inc.

This plan document highlights the provisions of the Plan. Be sure to familiarize yourself with its contents, and keep it in a safe place where you can refer to it quickly when you need it.

This plan document explains how the Plan works: what it pays for, what is not covered, how to submit expenses and claim benefits. Every medical cost situation cannot be specifically described in this material. If you have specific questions pertaining to coverage, please contact:

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

Phone: Please refer to the number shown on your Plan Identification Card
Website: www.aspirushealthplan.com

Table of Contents

1. SCHEDULE OF BENEFITS-$1,500 HDHP PLAN

Unless otherwise stated in the Plan, all *health care services* are subject to the *deductible* amounts, *coinsurance*, and *out-of-pocket limits* stated below and all other exclusions and limitations described in the Plan (e.g., *medically necessary*, *prior authorization* requirements, visit limits, step therapy, etc.).

You and your *health care provider* must obtain our *prior authorization* before receiving certain *health care services*. If you do not obtain our *prior authorization*, this may result in no *benefits* being paid. Refer to Section 7. (Obtaining Services) of the Plan for information about *prior authorization* requirements.

Deductible		
The annual *deductible* amount applies each *calendar year*. *Charges* for *covered expenses* directly provided to you must add up to this *deductible* amount before benefits are payable for other *charges* for *covered expenses*, unless specifically stated otherwise below. *Non-participating deductible* amounts will credit towards the *participating provider deductible*, but not vice versa. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a *participating facility* will be paid subject to applicable *participating provider deductible*.		
	Participating Providers	Non-Participating Providers
Single Coverage	$1,500	$1,500
Family Coverage If more than one person in a family is covered under the Plan, the *single coverage deductible* amount stated above does not apply. For *family coverage*, the *family coverage deductible* applies. No one in the family is eligible to receive *benefits* until the *family coverage deductible* is satisfied.	$3,000	$3,000
Coinsurance		
Coinsurance is the amount you pay for a covered service as stated below, unless specifically stated otherwise in the Plan. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a participating facility will be paid subject to applicable *participating provider coinsurance* provisions.		
	Participating Providers	Non-Participating Providers
Coinsurance:	10%	30%
Annual Out-of-Pocket Limit		
This is the *out-of-pocket limit* amount that you are required to pay each *calendar year* for covered *health care services* provided by a *participating provider* or *non-participating provider*. Any of the following costs will count towards your annual *out-of-pocket limit*: (1) your *deductible*; and (2) *coinsurance* amounts you pay for covered expenses associated with *health care services* provided by a *participating provider* or *non-participating provider*. *Non-participating out-of-pocket* limit amounts will credit towards the *participating provider out-of-pocket*, but not vice versa. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a *participating facility* will be paid subject to applicable *participating provider out-of-pocket limit*.		
	Participating Providers	Non-Participating Providers
Single Coverage	$2,000	$3,000
Family Coverage If more than one person in a family is covered under the Policy, the *single*	$4,000	$6,000

coverage out-of-pocket amount stated above does not apply. For *family coverage*, the *family coverage out-of-pocket limit* applies.		
Maximum Out-of-Pocket Limit		
This is the maximum *out-of-pocket limit* amount that you are required to pay each *calendar year* for covered *health care services* provided by a *participating provider* or *non-participating provider*. Any of the following costs will count towards your annual *out-of-pocket limit*: (1) your *deductible*; (2) *copayments;* and (3) *coinsurance* amounts you pay for covered expenses associated with *health care services* provided by a *participating provider* or *non-participating provider*. *Non-participating out-of-pocket* limit amounts will credit towards the *participating provider out-of-pocket*, but not vice versa. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a *participating facility* will be paid subject to applicable *participating provider out-of-pocket limit*.		
	Participating Providers	Non-Participating Providers
Per *Covered Person*	$6,650	$6,650
Per Family	$13,300	$13,300
Covered Expenses – Excluding Covered Drugs and Covered Supplies Dispensed by a Pharmacy		
	The Amount You Pay for Services by Participating Providers	The Amount You Pay for Services by Non-Participating Providers
Ambulance Services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Autism Services	Deductible and Coinsurance	Deductible and Coinsurance
Behavioral Health Services	Deductible and Coinsurance	Deductible and Coinsurance
Breastfeeding Equipment	0%	Deductible and Coinsurance
Chiropractic Services (Manipulations and office visits)	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives for Birth Control	0%	Deductible and Coinsurance
Diagnostic X-Ray (including *High-Technology Imaging*) and Laboratory Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Medical Care	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Emergency Room Services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Hospital Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	Deductible and Coinsurance
Kidney Disease Treatment	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional Counseling	0%	Deductible and Coinsurance
Office Visits – visit charge only	Deductible and Coinsurance	Deductible and Coinsurance

Preventive Care Services – services must be coded as preventive to paid at 100%. *Deductible* and *coinsurance* will apply to services not coded as preventive. • Well-baby care, well-child- care and adolescent well-care • Vision exam (includes refraction) • Immunizations and vaccinations • Preventive lab services and x-ray • Gynecological exam • Pap smear to screen for cervical cancer • Mammogram to screen for breast cancer • Physical exam • Digital prostate exam • Colonoscopy, sigmoidoscopy screening for colorectal cancer	0%	Deductible and Coinsurance
Surgical Services	Deductible and Coinsurance	Deductible and Coinsurance
Telemedicine Visits	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular Joint Disorders (TMJ)	Deductible and Coinsurance	Deductible and Coinsurance
Therapy Visits (physical/speech/occupational)	Deductible and Coinsurance	Deductible and Coinsurance
Transplant Services Donor expenses limited to $10,000 for Non- Participating Providers	Deductible and Coinsurance	Deductible and Coinsurance
Urgent Care	Deductible and Coinsurance	Deductible and Coinsurance
All Other Health Care Services	Deductible and Coinsurance	Deductible and Coinsurance

Covered Drugs and Covered Supplies

The following provisions apply when covered drugs or covered supplies are dispensed by a participating pharmacy. Covered drugs or covered supplies dispensed by non-participating pharmacy are not payable except for emergencies outside of the Aspirus Health Plan, Inc. *geographical service area*.

	Participating Pharmacy	
Copayments ***Copayments* apply only *after* the *deductible* has been satisfied.**		Retail & Home Delivery
		90-day supply
	Generic	$5 Copayment
	Preferred Brand-Name	$20 Copayment
	Brand-Name	$40 Copayment
	Specialty Medications	25% to $100 (limited to 30-day supply)
	Oral chemotherapy drugs are limited to $100 copayment	
Payment of Benefits	*Participating Provider Deductible, Copayment*, then 0%	
Preventive Drugs – as defined in Plan	0%	

2. SCHEDULE OF BENEFITS-$2,250 RETIREE HDHP PLAN

Unless otherwise stated in the Plan, all *health care services* are subject to the *deductible* amounts, *coinsurance*, and *out-of-pocket limits* stated below and all other exclusions and limitations described in the Plan (e.g., *medically necessary*, *prior authorization* requirements, visit limits, step therapy, etc.).

You and your *health care provider* must obtain our *prior authorization* before receiving certain *health care services*. If you do not obtain our *prior authorization*, this may result in no *benefits* being paid. Refer to Section 7. (Obtaining Services) of the Plan for information about *prior authorization* requirements.

Deductible

The annual *deductible* amount applies each *calendar year*. *Charges* for *covered expenses* directly provided to you must add up to this *deductible* amount before benefits are payable for other *charges* for *covered expenses*, unless specifically stated otherwise below. *Non-participating deductible* amounts will credit towards the *participating provider deductible*, but not vice versa. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a *participating facility* will be paid subject to applicable *participating provider deductible*.

	Participating Providers	Non-Participating Providers
Single Coverage	$2,250	$4,250
Family Coverage If more than one person in a family is covered under the Plan, the *single coverage deductible* amount stated above does not apply. For *family coverage*, the *family coverage deductible* applies. No one in the family is eligible to receive *benefits* until the *family coverage deductible* is satisfied.	$4,500	$8,500

Coinsurance

Coinsurance is the amount you pay for a covered service as stated below, unless specifically stated otherwise in the Plan. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a participating facility will be paid subject to applicable *participating provider coinsurance* provisions.

	Participating Providers	Non-Participating Providers
Coinsurance:	0%	30%

Annual Out-of-Pocket Limit

This is the maximum *out-of-pocket limit* amount that you are required to pay each *calendar year* for covered *health care services* provided by a *participating provider* or *non-participating provider*. Any of the following costs will count towards your annual *out-of-pocket limit*: (1) your *deductible*; and (2) *coinsurance* amounts you pay for covered expenses associated with *health care services* provided by a *participating provider* or *non-participating provider*. *Non-participating out-of-pocket* limit amounts will credit towards the *participating provider out-of-pocket*, but not vice versa. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a *participating facility* will be paid subject to applicable *participating provider out-of-pocket limit*.

	Participating Providers	Non-Participating Providers
Single Coverage	$2,250	$5,250
Family Coverage	$4,500	$10,500

If more than one person in a family is covered under the Policy, the *single coverage out-of-pocket* amount stated above does not apply. For *family coverage*, the *family coverage out-of-pocket limit* applies.		
Covered Expenses – Excluding Covered Drugs and Covered Supplies Dispensed by a Pharmacy		
	The Amount You Pay for Services by Participating Providers	The Amount You Pay for Services by Non-Participating Providers
Ambulance Services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Autism Services	Deductible and Coinsurance	Deductible and Coinsurance
Behavioral Health Services	Deductible and Coinsurance	Deductible and Coinsurance
Breastfeeding Equipment	0%	Deductible and Coinsurance
Chiropractor (Manipulations and office visits)	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives for Birth Control	0%	Deductible and Coinsurance
Diagnostic X-Ray (including *High-Technology Imaging*) and Laboratory Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Medical Care	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Emergency Room Services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Hospital Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	Deductible and Coinsurance
Kidney Disease Treatment	Deductible and Coinsurance	Deductible and Coinsurance
Injections (other than injections billed as a surgical procedure) - outpatient	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional Counseling	0%	Deductible and Coinsurance
Office Visits – visit charge only	Deductible and Coinsurance	Deductible and Coinsurance

Preventive Care Services – services must be coded as preventive to paid at 100%. *Deductible* and *coinsurance* will apply to services not coded as preventive. • Well-baby care, well-child- care and adolescent well-care • Vision exam (includes refraction) • Immunizations and vaccinations • Preventive lab services and x-ray • Gynecological exam • Pap smear to screen for cervical cancer • Mammogram to screen for breast cancer • Physical exam • Digital prostate exam • Colonoscopy, sigmoidoscopy screening for colorectal cancer	0%	Deductible and Coinsurance
Surgical Services	Deductible and Coinsurance	Deductible and Coinsurance
Telemedicine Visits	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular Joint Disorders (TMJ)	Deductible and Coinsurance	Deductible and Coinsurance
Therapy Visits (physical/speech/occupational)	Deductible and Coinsurance	Deductible and Coinsurance
Transplant Services Donor expenses limited to $10,000 for Non- Participating Providers	Deductible and Coinsurance	Deductible and Coinsurance
Urgent Care	Deductible and Coinsurance	Deductible and Coinsurance
All Other Health Care Services	Deductible and Coinsurance	Deductible and Coinsurance

Covered Drugs and Covered Supplies

The following provisions apply when covered drugs or covered supplies are dispensed by a participating pharmacy. Covered drugs or covered supplies dispensed by non-participating pharmacy are not payable except for emergencies outside of the Aspirus Health Plan, Inc. *geographical service area*.

	Participating Pharmacy
Payment of Benefits	*Benefits* are payable for covered supplies and covered drugs, including oral chemotherapy drugs, subject to the *participating provider deductible, coinsurance* and *out-of-pocket limits* of the Plan. This *benefit* does not apply to *preventive drugs*. See below for *preventive drug*s.
Preventive Drugs	0%

3. SCHEDULE OF BENEFITS-$500 TRADITIONAL COPAYMENT PLAN

Unless otherwise stated in the Plan, all *health care services* are subject to the *deductible* amounts, *copayments*, *coinsurance*, and *out-of-pocket limits* stated below and all other exclusions and limitations described in the Plan (e.g., medically necessary, *prior authorization* requirements, visit limits, step therapy, etc.).

You and your *health care provider* must obtain our *prior authorization* before receiving certain *health care services*. If you do not obtain our *prior authorization*, this may result in no *benefits* being paid. Refer to Section 7. (Obtaining Services) of the Plan for information about *prior authorization* requirements.

Deductible		
The *deductible* amount applies each *calendar year*. *Charges* for *covered expenses* directly provided to you must add up to this *deductible* amount before benefits are payable for other *charges* for *covered expenses*, unless specifically stated otherwise below. *Non-participating deductible* amounts will credit towards the *participating provider deductible*, but not vice versa. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a *participating facility* will be paid subject to applicable *participating provider deductible.*		
	Participating Providers	Non-Participating Providers
Per *Covered Person*	$500	$500
Per Family	$1,000	$1,000
Coinsurance		
Coinsurance is the amount you pay for a covered service as stated below, unless specifically stated otherwise in the Plan. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a participating facility will be paid subject to applicable *participating provider coinsurance* amount.		
	Participating Providers	Non-Participating Providers
Coinsurance:	10%	30%
Out-of-Pocket Limit		
This is the *out-of-pocket* amount that you are required to pay each *calendar year* for covered *health care services* provided by a *participating provider* or *non-participating provider*. Any of the following costs will count towards your *out-of-pocket limit*: (1) your *deductible*; and (2) *coinsurance* amounts you pay for *covered expenses* associated with *health care services* provided by a *participating* or *non-participating provider*. *Non-participating out-of-pocket* limit amounts will credit towards the *participating provider out-of-pocket*, but not vice versa. Radiology, pathology, anesthesia and emergency room services provided by a *non- participating provider*, but performed at a *participating facility* will be paid subject to applicable *participating provider out-of- pocket limit.*		
	Participating Providers	Non-Participating Providers
Per Covered Person	$2,000	$3,000
Per Family	$4,000	$6,000

Maximum Out-of-Pocket Limit		
This is the *out-of-pocket* amount that you are required to pay each *calendar year* for covered *health care services* provided by a *participating provider* or *non-participating provider*. Any of the following costs will count towards your *out-of-pocket limit*: (1) your *deductible*; (2) *copayments*; and (3) *coinsurance* amounts you pay for *covered expenses* associated with *health care services* provided by a *participating* or *non-participating provider*. *Participating* and *non-participating maximum out-of-pocket* amounts mutually satisfy one another. Radiology, pathology, anesthesia and emergency room services provided by a *non-participating provider*, but performed at a *participating facility* will be paid subject to applicable *participating provider out-of-pocket limit*.		
	Participating Providers (What you pay)	Non-Participating Providers (What you pay)
Per *Covered Person*	$7,350	$7,350
Per Family	$14,700	$14,700
Covered Expenses – Excluding Covered Drugs and Covered Supplies Dispensed by a Participating Pharmacy		
	The Amount You Pay for Services Provided by Participating Providers	The Amount You Pay for Services Provided by Non-Participating
Ambulance Services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Autism Services	Deductible and Coinsurance	Deductible and Coinsurance
Behavioral Health Services Therapy Visits Inpatient Services Outpatient/Transitional Services All other services	 0% (No Deductible) Deductible 0% (No Deductible) Deductible and Coinsurance	 10% Coinsurance (No Deductible) Deductible 10% Coinsurance (No Deductible) Deductible and Coinsurance
Breastfeeding Equipment	0%	Deductible and Coinsurance
Chiropractic Services (Manipulations, therapies and office visits)	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives for Birth Control	0%	Deductible and Coinsurance
Diagnostic X-Ray (including High-Technology Imaging) and Laboratory Services – provided on an outpatient basis, other than in an emergency room	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Medical Care	Deductible, Copayments, if applicable, and Coinsurance	Participating Provider Deductible, Copayments, if applicable, and Coinsurance
Emergency Room – room charge only	$100 Copayment, 0%	$100 Copayment, 0%
Emergency Room Services	Deductible and Coinsurance	Participating Deductible and Coinsurance
Hospital Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	Deductible and Coinsurance
Injections (other than injections billed as a surgical procedure) - outpatient	Deductible and Coinsurance	Deductible and Coinsurance

Nutritional Counseling	0%	Deductible and Coinsurance
Office Visits – visit charge only Primary Care Practitioner Specialty Care Practitioner	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible
Preventive Care Services – services must be coded as preventive to paid at 100%. *Deductible* and *coinsurance* will apply to services not coded as preventive. • Well-baby care, well-child- care and adolescent well-care • Vision exam (includes refraction) • Immunizations and vaccinations • Preventive lab services and x-ray • Gynecological exam • Pap smear to screen for cervical cancer • Mammogram to screen for breast cancer • Physical exam • Digital prostate exam • Colonoscopy, sigmoidoscopy screening for colorectal cancer	0%	Deductible and Coinsurance
Surgical Services	Deductible and Coinsurance	Deductible and Coinsurance
Telemedicine Visits	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular Joint Disorders (TMJ)	Deductible and Coinsurance	Deductible and Coinsurance
Therapy Visits (physical/speech/occupational) Office Setting Home or Outpatient Hospital Setting	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
Transplant Services Donor expenses limited to $10,000 for Non-Participating Providers	Deductible and Coinsurance	Deductible and Coinsurance
Urgent Care – visit charge only	Deductible and Coinsurance	Deductible and Coinsurance
All Other *Health Care Services*	Deductible and Coinsurance	Deductible and Coinsurance

Covered Drugs and Covered Supplies	
The following provisions apply when covered drugs or covered supplies are dispensed by a *participating pharmacy*. Covered drugs or covered supplies dispensed by non-*participating pharmacy* are not payable except for emergencies outside of the Aspirus Health Plan, Inc. geographical service area.	
	Participating Pharmacy
Copayments: These *copayments* do not apply to *preventive drugs.* **The *copayment* for oral chemotherapy drugs shall not exceed $100** (limited to a 30-day supply)	Dispensed by a Pharmacy and Home Delivery
	90-day Supply
	Generic: $5
	Preferred Brand-Name: $20
	Brand-Name: $40
	Specialty: 25% to $100 (limited to a 30-day supply)
	Diabetic Supplies: $0
Coinsurance – after applicable *copayment*, excludes *preventive drugs*	0%
Coinsurance for *preventive drugs*	0%

4. SUMMARY PLAN DESCRIPTION

Federal law under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, requires that certain information be furnished to each *covered person* of the Plan in an employer's welfare benefit plan. For this coverage, the Plan's entire plan document along with the following information is the Summary Plan Description for purposes of ERISA. If you have any questions, please call the telephone number shown on your Plan identification card.

A Summary Plan Description (SPD) will be made available online for each employee covered under the Plan. This is the plan document and SPD for the Plan. It contains information on: eligibility, termination; benefits provided; and other general Plan provisions.

PLAN NAME
Wausau School District, Employee Benefit Plan

PLAN SPONSOR'S NAME AND ADDRESS
Wausau School District
415 Seymour Street
Wausau, WI 54401

SPONSOR'S EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER
The Employer Identification Number (EIN) assigned for the Plan by the Internal Revenue Service is 39-1410384. The Plan number for the medical of the Plan assigned by the Employer is 501.

TYPE OF BENEFIT PLAN
A self-funded benefit Plan providing certain participating provider Plan benefits to *covered employee*s and dependents.

TYPE OF ADMINISTRATION
The administration of the Plan is under the supervision of the Plan Sponsor. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. The *Claim Administrator* provides administrative services such as claim payments for medical claims.

PLAN YEAR FOR GOVERNMENT REPORTING
July 1 – June 30

PLAN ADMINISTRATOR'S NAME, ADDRESS AND PHONE NUMBER
Wausau School District
415 Seymour Street
Wausau, WI 54401
715-261-0515

CLAIM ADMINISTRATOR
Aspirus Health Plan, Inc.
P.O. Box 59212
Minneapolis, MN 55459-0212

AGENT FOR SERVICE OF LEGAL PROCESS
Legal process may be served on the Plan Administrator. The street address at which process may be served is:
Wausau School District
415 Seymour Street
Wausau, WI 54401

ELIGIBILITY REQUIREMENTS TO RECEIVE BENEFITS
For detailed information regarding a person's eligibility to participate in the Plan, refer to the following section:

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

For detailed information regarding a person's being ineligible for benefits through reaching maximum benefit levels or termination of coverage, refer to the following sections:

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE
GENERAL EXCLUSIONS
WHEN COVERAGE ENDS

DESCRIPTION OF AVAILABLE BENEFITS
Please refer to Section 9. Covered Expenses of this benefit book for a description of benefits covered under the Plan.

SOURCE OF CONTRIBUTIONS TO THE PLAN
The Plan is funded by contributions from the *employer* and the *covered employee*s. The *employer* determines the amount of the employee's contributions and reserves the right to adjust or modify such contributions. All employee contributions are on a non-discriminatory basis.

METHOD OF FUNDING
The Plan is self-funded by the Plan Sponsor/Plan Administrator.

EXPLANATION OF CLAIMS PROCEDURES
Please refer to Section 16. Internal Claims and Appeals Procedures.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE
This notice is intended to inform you that pursuant to a new law, the Women's Health and Cancer Rights Act, you will be receiving additional benefits under your Group Health Plan beginning on January 1, 1999. The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA which amends ERISA, requires Group Health Plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because your Group Health Plan offers coverage for mastectomies, WHCRA applies to your Plan. The law mandates that a member who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible and coinsurance provisions otherwise applicable under your Group Health Plan.

If you have any questions regarding these benefits, please contact us at the toll-free number listed on your Group Health Plan ID card.

DISCRETIONARY AUTHORITY

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the *Claim Administrator*. Any interpretation, determination or other action of the Plan Administrator or *Claim Administrator* shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator or *Claim Administrator* shall be based only on such evidence presented to or considered by the Plan Administrator or the *Claim Administrator* at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the *Claim Administrator* makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described by this section.

MEDICARE AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you are eligible for health coverage from your *employer*, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for *employer*-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if the premium assistance is available at (for Wisconsin) 1-800-362-3002 or http://dhs.wisconsin.gov/Medicaid/publications/p-10095.htm.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insuredkidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an *employer*-sponsored Plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your *employer*'s health Plan is required to permit you and your dependents to enroll in the Plan – as long as you and your dependents are eligible, but not already enrolled in the *employer*'s Plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

STATEMENT OF ERISA RIGHTS

As a *covered person* of this welfare Plan, you have certain rights through the Employee Retirement Income Security Act of 1974 (ERISA). A member also has certain protections through ERISA. ERISA provides that all *covered employee*s will be entitled to:

Receive Information About Your Plan and Benefits:

1. Examine, without charge, all documents governing the Plan. A member may examine them at the Plan Administrator's office. A member may also examine them at other specified locations, such as work sites and union halls, if any. This includes insurance contracts and collective bargaining agreements, if any. It also includes the latest annual report (Form 5500 Series) filed by Plan with the U.S. Department of Labor. These filings are available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

2. Obtain copies of documents governing the Plan. This includes insurance contracts and collective bargaining agreements, if any. It also includes the latest annual report (Form 5500 Series) and an updated Summary Plan Description. Written request must be made to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each *covered employee* with a copy of this summary annual report.

Continue Group Health Plan Coverage:
Continue health care coverage for the *covered employee*, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The *covered employee* and his/her dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries:
ERISA also imposes duties on the people who are responsible for the Plan. The people who operate the Plan are called "fiduciaries" of the Plan. They have a duty to operate the Plan prudently and in the interest of you and other Plan members. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. This includes your *employer*, your union, if any, or any other person.

Alternate Recipients:
ERISA also creates rights and protections for the children of members by requiring that children of a member who are the subject of a Qualified Medical Child Support Order (QMCSO) be considered alternate recipients under the Plan. Such children, upon the Plan Administrator's determination that the order is a QMCSO, must be provided coverage under the Plan without regard to dependency requirements like custody, claimed on taxes, 50% support, enrollment periods or other similar limits regarding the eligibility of dependents. If a member does not enroll the child in the Plan, the Plan must recognize the alternate recipient's right to enroll or be enrolled by the custodial parent or legal guardian.

An alternate recipient or the custodial parent or legal guardian of the alternate recipient will be considered an employee under the Plan for purposes of reporting and disclosure under ERISA and must receive all necessary information, including a Summary Plan Description, so that the alternate recipient may be enrolled and receive benefits under the Plan. In addition, any payment made by the Plan on behalf of the alternate recipient must be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian (payment to the provider on behalf of the alternate recipient is also allowed).

A Qualified Medical Child Support Order is any judgment, decree or order issued by a court of competent jurisdiction pursuant to State domestic relations laws, including community property law, regarding benefits available under this Plan to a child of a member or which enforces a law relating to a medical child support under the Social Security Act and includes the following:

1. The name and last known mailing address of the member;

2. The name and address of each alternate recipient;

3. A description of the type of coverage to be provided or the manner in which coverage will be determined for each alternate recipient;

4. The period of time for which coverage is to be provided to each alternate recipient; and

5. Each plan to which the order applies.

A Qualified Medical Child Support Order will not entitle an alternate recipient to any benefits or coverage not already offered by the Plan.

Enforce Your Rights:
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done within certain time frames. You have the right to obtain copies of documents relating to the decision without charge and within certain time frames. You also have the right to appeal any denial, within certain time frames.

Under ERISA, there are steps you can take to enforce the above rights. For instance, such as Plan documents or the latest annual report, that you asked the Plan for are not received within 30 days, you may seek relief through binding arbitration. Binding arbitration will be under the rules of the American Arbitration Association. In such case, the Plan Administrator may be ordered to provide you with the materials. The Plan Administrator may also be ordered to pay you up to $110 a day until the materials are received. If the materials were not sent due to reasons beyond the Plan's control, penalties will not be imposed.

If you have a claim, or part of a claim, for benefits that is denied or ignored, you may only seek relief through binding arbitration. In addition, if you do not agree with the Plan's decision or lack of decision on the qualified status of a medical child support order, you may only seek relief through binding arbitration. If the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or seek relief through binding arbitration. The arbitrator will decide who should pay filing costs and legal fees. If you are successful, the person you have sued may be ordered to pay these costs and fees. If you lose, for example, your claim is found frivolous; you may be ordered to pay these costs and fees.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement, you should contact the nearest office of the Employee Benefits Security Administration. If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration. If you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration. You can contact the Employee Benefits Security Administration at the U.S. Department of Labor number listed in your telephone directory. You can also contact them at the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. Certain publications about your rights and responsibilities under ERISA can be obtained by calling the publications hotline of the Employee Benefits Security Administration.

5. GENERAL INFORMATION

A. General Description of Coverage

This Plan Document and Summary Plan Description describes the two benefit levels. One benefit level applies when you receive covered *health care services* from a *participating provider*. The other benefit level applies when you receive covered *health care services* from a *non-participating provider*.

B. Your Choice of Health Care Providers Affects Your Benefits

Participating providers are *health care providers* who are part of our network as shown on your Plan identification card. See Section 19. (Definitions) for more information.

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

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

If you use a *non-participating provider,* covered *charges* will be payable under this Plan up to the *out-of-network usual and customary amount* as defined in Section 19. (Definitions). If there is a difference between the amount that we pay and the amount that the *non-participating provider* bills, you are responsible for that amount.

C. Coverage

Coverage is subject to all terms, conditions and provisions of the Plan. This document describes the essential features of the coverage provided by the Plan.

This Plan Document and Summary Plan Description replaces and supersedes all other benefit books or plan documents which we may have previously issued to you prior to the effective date of this Plan Document and Summary Plan Description.

D. How to Use This Plan Document and Summary Plan Description

This Plan Document and Summary Plan Description, including its Schedule of Benefits and all summaries of material modifications, should be read carefully and completely by you. The provisions of this Plan Document and Summary Plan Description are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a clear or full understanding of your coverage under the Plan.

Each italicized term used in this Plan Document and Summary Plan Description has a special meaning. These terms are defined for you in Section 19. (Definitions) or in the definitions section of the relevant subsection. Whenever you come across an italicized word, please review its definition carefully so you understand what it means. By understanding these definitions, you will have a better understanding of your coverage under the Plan.

From time to time, the Plan may be amended or changed. When that happens, a Summary of Material Modification and/or a new Plan Document and Summary Plan Description will be made available online for each *covered employee*. That means your coverage under the Plan will change to the extent described in the Summary of Material Modification and/or a new Plan Document and Summary Plan Description, as of the effective date of the change.

This document and any amendments should be kept in a safe place for your future reference. Throughout this document, the terms “you” and “your” refer to any *covered person.* The terms “we”, “us”, and “our” refer to Aspirus Health Plan, Inc. as the *Claim Administrator*.

E. How to Get More Information

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

F. Covered Expenses

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

In certain circumstances for purposes of overall cost savings or efficiency, we have full discretionary authority to pay *benefits* for *health care services :* (1) at the *participating provider* level of benefits for a *health care service* provided by a *non-participating provider*; or (2) that are not covered under the Plan, to the limited extent provided in Section 9. C. (Covered Expenses / Alternative Care). The fact that we provide such coverage in one case will not require us to do so in any other case, regardless of any similarities between the two.

We have full discretionary authority to arrange for other persons or entities to provide administrative services related to the Plan, including claims processing and utilization management without notice to you. We also have full discretionary authority to authorize other persons or entities to exercise discretionary authority with regard to the Plan without notice to you. By accepting this Plan Document and Summary Plan Description, you agree to cooperate fully with those persons or entities in the performance of their responsibilities.

6. ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE

A. Employee Eligibility

An individual who meets the definition of *eligible employee* is eligible for coverage under this Plan on the first day of the calendar month following the employment date with the *employer*; however, if the employment date is the first workday of the month, coverage would begin on the first of that month (e.g. employment date is July 3, coverage would start July 1).

For employees returning from a leave of absence – coverage would align similar to employee eligibility noted above. Coverage would begin on the first day of the month following return to work – or, if the return is the first workday of the month, coverage starts on the first of the month.

B. Dependent Eligibility

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

C. Retiree Eligibility

1. Teachers

Applicants for voluntary retirement benefits must be regular degree-holding teachers prior to the age of Medicare eligibility, at least 55 years of age and eligible to draw retirement benefits under the Wisconsin Retirement System on or before December 31st of the school year following their retirement from the *employer*, as well as must meet the following criteria:

a. Except as otherwise stated in paragraph b. or c. below, teachers must have accumulated not less than the full-time equivalent of 10 years of services with the *employer* to be eligible for voluntary early retirement benefits.

b. Teachers employed as of December 31, 2005 who are 15 or more years below the age of eligibility to draw WRS benefits must accumulate not less than the full-time equivalent of 15 years of services with the *employer* to be eligible for voluntary early retirement benefits.

c. Teachers hired after December 31, 2005 must accumulate not less than the full-time equivalent of 15 years of continuous services to be eligible for voluntary retirement benefits.

2. Administrators

a. The employee who is at least 55 years of age on or before December 31st of the contract year following his/her official retirement and who has services a minimum of ten years as an administrator with the *employer* or has a minimum of 12 years of full-time administrative and teaching service with the *employer*, the last 5 years of which must be as an administrator, will be eligible for retirement benefits provided no more than 4 administrators have requested to participate in the program. If more than 4 administrators have applied for participation, the *employer* may elect to choose 4 recipients only on a first come, first serve basis in accordance with the application timelines stated herein.

b. The employee may apply for participation in the retirement program no later than December 15th, for participation beginning July of the next school year.

c. The Board will permit the retired employee and his/her spouse to remain on the *employe*r's group health and dental insurance plans from the time of separation for a period of ten years. During the 10 year period of coverage, the *employer* shall pay the full cost of the monthly health and dental insurance contributions to the existing health and dental insurance plans on behalf of the retired employee and his/her spouse, if applicable. If the retired employee or his/her spouse, if applicable, becomes eligible for Medicare during the 10 year period of coverage, the *employer* will provide for and pay the full premiums for Medicare carve-out insurance plan for Medicare as long as such combined coverage is reasonably similar to the existing health and dental insurance plans of all active administrative employees.

In the event the retired employee precedes his/her spouse in death, the spouse, if eligible by carrier standards, shall be able to remain in the *employer's* insurance plans until 10 years after the retired employee's retirement from the *employer* and the Board shall pay the full cost of the monthly health and dental insurance contributions to the existing health and dental insurance plans on behalf of the spouse during the 10 year period of coverage.

If, after the retired employee dies, but before the expiration of the 10 year period of coverage, the spouse becomes eligible for Medicare, the *employer* will provide for and pay the full premiums for a Medicare carve-out insurance plan for the spouse until the 10 year period of coverage expires.

In no event, however, shall the retired employee receive cash payments(s) in exchange for unused sick leave.

d. An eligible employee at age 54 whose 55th birth date occurs between August 31 and January 1 will be responsible for payment of his/her entire health and dental insurance premiums commencing in July until the month he/she reaches age 55.

3. Municipal

Employees who are over the age of 55 and have 10 or more consecutive years of services may use the value of their accumulated sick leave, based on the per diem value of the time of separation from employment.

D. How to Enroll

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

E. Initial Enrollment Period

When the group purchases coverage under the Plan, the initial enrollment period is the first period of time when *eligible employees* can enroll themselves and their *eligible dependents*. Coverage begins on the date identified in the Plan as long as we receive the completed application and any required premium **within 31 days** after the employee and any dependents become eligible to enroll.

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

F. Annual Enrollment Period

Each year there will be an enrollment period during which any *eligible employee* and/or *eligible dependents* can enroll under the Plan. The annual enrollment period also provides an opportunity for a *subscriber* to change to a different health insurance *plan*, if available. Any coverage selected will be effective on the first day of the month following the annual enrollment period.

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

The annual enrollment period will be the month of November for a January 1st effective date. The application for coverage must be received prior to *employer's* anniversary date.

G. Special Enrollment Periods

Certain life events or other circumstances may trigger a special enrollment period during which an *eligible employee* and/or *eligible dependent* will be able to enroll in the Plan outside the annual enrollment period. These circumstances are explained in Paragraphs 1. – 6. below.

Except as noted below, we generally must receive an application from the *eligible employee* listing all individuals he/she wants to enroll **within 31 days** after the *eligible employee* or *eligible dependent* experiences the special late enrollment circumstance (*e.g.*, birth, marriage, loss of coverage).

If an *eligible employee* has completed any *waiting period* required by the *employer*, he/she may enroll himself/herself and his/her *eligible dependents* if the *eligible employee* acquires an *eligible dependent* through marriage, birth, or adoption or *placement for adoption*.

If we timely receive an application, coverage for the *eligible employee* and/or his/her *eligible dependents* will begin on the first day of the calendar month following the date of marriage or on the date the *eligible employee* experiences the special late enrollment circumstance due to birth, adoption or *placement for adoption* of a *child*, or by court order. If we do not receive the application within this time period, you may have to wait until the next annual enrollment period to add or change your coverage.

1. Eligibility for Premium Assistance Subsidy under Medicaid

If an *eligible employee* or *eligible dependent* previously declined coverage under the Plan, but later becomes eligible for a premium assistance subsidy under Medicaid, including BadgerCare Plus or the Children's Health Insurance Program (CHIP), the *eligible employee* or *eligible dependent* may enroll in the Plan by submitting an application **within 60 days** after they are determined to be eligible for the subsidy.

2. Loss of Other Health Care Coverage

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

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

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

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

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

1) Loss of eligibility;

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

3) COBRA continuation coverage ended;

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

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

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

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

If health care coverage is lost for one of the reasons outlined in Paragraph 2. c. 1) – 6) above, coverage for the *eligible employee* and/or his/her *eligible dependents* under the Plan will begin on the first day following the date the *eligible employee*'s other health coverage ended if we receive an application **within 31 days** after the loss of other health care coverage. If health care coverage is lost for the reason outlined in Paragraph 2. c. 7) (*loss* of eligibility for Medicaid), coverage for the *eligible employee* and/or his/her *eligible dependents* under the Plan will begin on the first day following the date the *eligible employee*'s or *eligible dependent's* other health coverage ended if we receive an application **within 60 days** after the loss of other health care coverage. Otherwise, the *eligible employee* and/or *eligible dependents* may not be added until the next annual enrollment period.

3. Marriage

If a *subscriber* acquires one or more *eligible dependents* through marriage, he/she may enroll any *eligible dependents*. If we receive an application **within 31 days** after the date of marriage, the *eligible dependents*' coverage will be effective on the date of marriage. Otherwise, the spouse and other *eligible dependents* may not be added until the next annual enrollment period.

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

4. Birth of a Child

You must notify us of the *child's* birth.

We must receive an enrollment form listing the *child(ren)* the *subscriber* wants to enroll **within 31 days** after the date of the *child's* birth.

If we do not receive the application **within 31 days** after the *child's* birth, the newborn may not be added until the next enrollment period.

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

You must notify us of the *child's* adoption or *placement for adoption*.

We must receive an application listing the *child(ren)* the *subscriber* wants to enroll within 31 days after the date of the adoption or *placement for adoption*. The effective date for such *family coverage* will be one of the following: (a) the date a court makes a final order granting adoption of the *child* by the *subscriber*; (b) the date that the *child* is *placed for adoption* with the *subscriber*; or (c) a later date elected by the *subscriber*. If we receive the enrollment form after the 31-day period ends, the *child(ren)* may not be added until the next annual enrollment period.

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

6. Child Support Order

We will provide coverage in accordance with a Qualified Medical Child Support Order (QMCSO), National Medical Support Notice (NMSN), or other qualified medical child support order pursuant to the applicable requirements under § 609 of the Employee Retirement Income Security Act (ERISA) and § 1908A of the Social Security Act and any other applicable laws. It is the *employer's* responsibility to determine whether a medical child support order is qualified.

Upon receipt of a medical child support order issued by an appropriate court or governmental agency, the employer will follow its established procedures for determining whether the medical child support order is qualified. The *employer* will provide us with notice of the medical child support order and a copy of the order along with an application for coverage within the greater of 31 days after issuance of the order or the time in which the *employer provides* notice of its determination to the persons specified in the order.

Where a medical child support order requires coverage to be provided under the Plan and an *eligible employee's child* is not already a *covered dependent*, then such *child* will be provided a special enrollment period. If the *eligible employee* whose *child* is the subject of the medical child support order is not enrolled at the time enrollment for the *child* is requested, then the *eligible employee* must also enroll for coverage under the Plan during the special enrollment period. The effective date of coverage will either be the date the medical child support order is issued or pursuant to another coverage date set forth in the medical child support order.

Where a medical child support order requires coverage to be provided for under the Plan for an *eligible employee's child* who is already a *covered dependent*, such *child* will continue to be provided coverage under the Plan pursuant to the terms of the medical child support order.

7. OBTAINING SERVICES

A. Choosing a Primary Care Practitioner

Each *covered person* must choose a *primary care practitioner* (*PCP*) from our directory of *participating providers* and notify us of his/her selection. You may choose any *PCP* who participates in our network and who is available to accept you. For *children*, a *subscriber* may designate a participating pediatrician as the *child's PCP*. Please note that if you do not choose a *PCP*, we may designate one for you.

Regardless of who you choose as your *PCP*, no referral is required to receive *health care services* from a *participating provider* who specializes in obstetrics and gynecology.

For a complete list of *PCPs* in your network, please use the "Find A Doctor" tool on our website or contact Customer Service. Although you may change your *PCP* at any time, we encourage you to establish a relationship with one *PCP*. You must notify us each time you select a different *PCP*.

B. Participating Provider Benefits

1. Except as stated in the Plan, *participating provider benefits* are payable only when you receive *health care services* from:

a. A *participating provider*;

b. A *non-participating provider* if you have submitted and we have approved a prior authorization to seek *health care services* from that provider. We will only approve *health care services* provided by a *non-participating provider* when those health care services are not available from a *participating provider* and necessary to treat your illness or injury;

c. A radiologist, pathologist, or anesthesiologist who is on staff at a participating *hospital* or ordered by a *participating provider*; or

d. A radiologist, pathologist, or anesthesiologist who is on staff at a non-participating *hospital* if you have submitted and we have approved a *prior authorization* to seek *health care services* at a non-participating *hospital*.

2. *Participating providers* are not permitted to bill you for any *medically necessary covered expenses* above the *usual and customary amount*. *Health care services* you receive from *participating providers* are only subject to your *deductible*, *copayments*, and *coinsurance*. See Section 8. (Payment of Benefits) for additional information about the costs you are responsible for under the Plan.

3. If you receive any *health care services* from a *non-participating provider*, even those approved under paragraph 1. above, the *non-participating provider* may bill you for the difference between the amount billed and the amount that we determine to be the *usual and customary amount*.

C. Non-Participating Provider Benefits

If you receive *health care services* from a *non-participating provider*, *benefits* provided are limited to the *out-of-network usual and customary amount* and you will be responsible for paying any difference between that amount and the *charge* billed. For example, if the *non-participating provider's charge* is $1,000 and the *out-of-network usual and customary amount* is $700, you will be responsible for paying the remaining balance of $300 in addition to any applicable *copayment*, *deductible* or *coinsurance* amounts.

When a *covered person* has obtained a *prior authorization* or has an out-of-network *emergency room visit*, *benefits* will be payable at either: (1) the negotiated discount amount; or (2) at 100% of the amount billed by the *non-participating provider*.

D. Prior Authorization

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

2. **When Do I Have to Obtain Prior Authorization?** You are required to obtain *prior authorization* before you visit certain *health care providers* or receive certain *health care services*, such as planned inpatient admissions, pain management, spinal surgery, new technologies (which may be considered *experimental/investigational/unproven*), non-emergency ambulance services, high-cost *durable medical equipment*, *genetic testing*, *prescription legend drugs*, or procedures that could potentially be considered *cosmetic treatment*. A current list of *health care providers* and *health care services* for which *prior authorization* is required is located on our website at www.aspirushealthplan.com. Please refer to this website often, as we have full discretionary authority to change it from time to time without notice to you.

3. **How do I Request Prior Authorization?**
   a. *Health Care Services* Other Than *Prescription Legend Drugs*: Ask your *health care practitioner* to contact our Customer Service Department by calling the telephone number shown on your identification card or to download, complete, and submit the printable Prior Authorization Form on our website. You should then call Customer Service to verify that we have received the *prior authorization* request. Please note that for genetic services, we will not accept *prior authorization* requests from the laboratory that will perform the genetic services unless there is supporting documentation from the ordering *health care provider*.

   b. *Prescription Legend Drugs: Prescription legend drugs* that require *prior authorization* are noted on our website at www.aspirushealthplan.com. Your *health care practitioner* should contact us or our *delegate*, as indicated, to initiate the process. To find out about the *prior authorization* process for *prescription legend drugs*, see Section 9. KK. (Covered Expenses / Prescription Legend Drugs and Supplies).

4. **What Happens After My Provider Submits the Prior Authorization Request?** After we, or our *delegate*, receive your *health care provider's* request, we, or our *delegate*, will review all of the documentation provided and send a written response to you and/or the *health care provider* who submitted the request within the timeframe required by law. See Section 16. (Internal Claims and Appeal Procedures) for additional details.

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

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

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

7. **My Prior Authorization Request Was Denied – Now What?** If we disapprove your request for a *health care service*, you can request that we review and reconsider the denial of *benefits* by following the procedures outlined in Section 16. (Internal Claims and Appeal Procedures).

   If we disapprove your request for a *health care service* from a *non-participating provider*, because we determine services are available from a *participating provider*, benefits may still be available as stated in the Schedule of Benefits for *non-participating providers.* You can request that we review and reconsider the denial of the *prior authorization* request by following the procedures outlined in Section 16. (Internal Claims and Appeals Procedures).

8. **What Happens If I Do Not Obtain a Prior Authorization?** Failure to comply with our *prior authorization* requirements will initially result in no *benefits* being paid under the Plan. If, however, *benefits* are denied solely because you did not obtain our *prior authorization*, you can request that we review and reconsider the denial of *benefits* by following the procedures outlined in Section 16. (Internal Claims and Appeal Procedures). If we determine that the *health care service* would have been covered under the Plan if you had followed the *prior authorization* process, we will reprocess the affected claim(s) in accordance with your standard *benefits*.

9. **What Health Care Services Do Not Require a Prior Authorization?** You do not need a *prior authorization* from us or any other person (including your *PCP*) to obtain:

   a. Obstetrical or gynecological (OB/GYN) care from a *participating provider* who specializes in obstetrics or gynecology. The *participating provider*, however, may be required to comply with certain procedures, including obtaining a *prior authorization* for certain *health care services*, following a pre-approved *treatment* plan, or making referrals. For a list of participating OB/GYN providers, use the "Find A Doctor" tool on our website or contact Customer Service.

   b. Emergency medical care or urgent care at an emergency or urgent care facility.

   c. Covered radiologist, pathologist and anesthesiologist services at a participating facility.

E. Referrals

Situations not related to a *medical emergency* may arise that make it *medically necessary* for you to obtain *health care services* from a *non-participating provider*. For example, this might occur if there is not a *participating provider* with the expertise to provide *health care services* that are *medically necessary* and a *covered expense*. We have full discretionary authority to provide coverage for *health care services* provided by a *non-participating provider* at the *participating provider* level of *benefits*.

In order for us to provide coverage at the *participating provider* level of *benefits*, the *health care services* must be *medically necessary*, as determined by us, and received during a period of time specified by us. Also, prior to your receipt of the *health care services*, a referral must be: (1) requested by a *participating provider*, (2) provided to us in writing, and (3) approved by us in writing. If you receive *health care services* from a *non-participating provider*, the *non-participating provider* may bill you for the difference between the *charge* and the amount we determine to be the *maximum allowable*.

F. Coding Errors

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

G. Our Utilization Management Program

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

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

8. PAYMENT OF BENEFITS

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

A. Deductible

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

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

Non-participating provider deductibles amounts credit towards the *participating provider deductible*, but not vice versa.

B. Coinsurance

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

C. Copayments

Your *copayments* (if applicable) are set forth in your Schedule of Benefits. *Copayment* amounts may vary by the type of service. You may also have a *copayment* when you get a prescription filled. See Section 9. KK. (Covered Expenses / Prescription Legend Drugs and Supplies) for information about prescription *copayments*.

If you receive *health care services* other than emergency room care at a *hospital*-based outpatient clinic location, your bill may show two separate *charges* – one for the *health care practitioner* and one for the facility. The *copayment* only applies to the *charge* billed by the *health care practitioner*. Facility *charges* are subject to the applicable *deductible* and *coinsurance* amounts of the Plan. See Section 9. T. (Covered Expenses / Emergency Medical Care).

D. Out-of-Pocket Limits

Your *out-of-pocket limits* are set forth in your Schedule of Benefits. After your *out-of-pocket limit* is reached, we will pay 100% of the *charges* up to the *usual and customary amount* for covered *health care services* you receive during the remainder of the *calendar year*, subject to all other terms, conditions and provisions of the Plan.

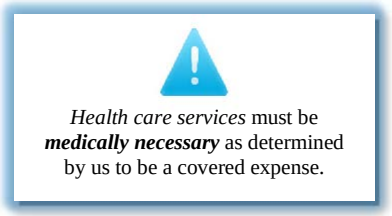
Non-participating out-of-pocket limit amounts will credit towards the *participating out-of-pocket*, but not vice versa.

E. Usual and Customary Amount

We'll pay *charges* for the *covered expenses* described in Section 9. (Covered Expenses) up to the *usual and customary amount*. If you see a *non-participating provider*, you are solely responsible for paying any *charge* that exceeds the *out-of-*

network usual and customary amount. Regardless of what *health care provider* you see, you are also solely responsible for paying any *charge* for a *health care service* that we do not cover under the Plan.

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



9. COVERED EXPENSES

Health care services described in this Section 9. are *covered expenses* as long as they are *medically necessary*, ordered and provided by a *health care provider* licensed to provide them and not subject to an exclusion or limitation outlined in this section and Section 10. (General Exclusions). If a *health care service* is not listed in this Section 9., it is not covered under the Plan and no *benefits* are payable for it.

Please note that any of the *health care services* listed below may require our *prior authorization*. Please see Section 7. D. (Obtaining Services / Prior Authorization) for detailed information about our *prior authorization*s. Additionally, all *benefits* are subject to the *deductible*, *coinsurance* and *copayment* amounts, *out-of-pocket limits*, and all other provisions stated in the Schedule of Benefits. See Section 8. (Payment of *Benefits*) for an explanation of these cost-sharing structures.

A. Alcoholism Treatment

See Section 9. G. (Covered Expenses / Behavioral Health Services) for *benefits* for alcoholism and other *substance use disorders.*

B. Allergy Testing and Treatment

Therapy and testing for *treatment* of allergies.

C. Alternative Care

If your attending *health care practitioner* advises you to consider alternative care for an *illness* or *injury* that includes *health care services* not covered under the Plan, your attending *health care practitioner* should contact us so we can discuss it with him/her. We have full discretionary authority to consider paying for such non-covered *health care services* and we may consider an alternative care plan if we find that:

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

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

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

D. Ambulance Services

1. *Ambulance services* used to transport you when you are sick or injured:

a. From your home or the scene of an accident or *medical emergency* to a *hospital*;

b. Between *hospitals*;

c. Between a *hospital* and a *skilled nursing facility*;

d. From a *hospital* or a *skilled nursing facility* to your home for hospice care; or

e. From your home to a facility for *hospice care* covered under Section 9. Z. (Covered Expenses / Hospice Care).

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

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

4. *Benefits* are not payable for *ambulance services*:

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

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

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

d. When *ambulance services* are called, but you are not transported (please note that any *emergency medical care* provided to you will be payable under Section 9. T. (Emergency Medical Care)

E. Anesthesia Services

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

F. Autism Services

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

This Section 9. F. is not subject to the exclusions in Section 10. (General Exclusions). The only exclusions that apply to this Section are outlined below in Paragraph 2 below (Autism Services Exclusions).

1. **Covered Autism Services**:

   a. Diagnostic testing. The testing tools used must be appropriate to the presenting characteristics and age of the *covered person* and empirically valid for diagnosing autism spectrum disorders consistent with the criteria provided in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. We reserve the right to require a second opinion with a provider mutually agreeable to the *covered person* and us.

   b. Intensive-level services. We will provide up to four years of intensive-level services that commence after you are two years of age and before you are nine years of age. The majority of the services must be provided to you when your parent or legal guardian is present and engaged. While receiving intensive-level services, you must be directly observed by the qualified provider at least once every two months. In addition, the intensive-level services must be all of the following:

      1) Evidence-based.

      2) Provided by a qualified provider, professional, therapist, or paraprofessional, as those terms are defined by state law.

      3) Based on a treatment plan developed by a qualified provider or professional as defined by state law that includes an average of 20 or more hours per week over a six-month period of time with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that you be present and engaged in the intervention.

      4) Provided in an environment most conducive to achieving the goals of your treatment plan.

      5) Assessed and documented throughout the course of treatment. We may request and review your treatment plan and the summary of progress on a periodic basis.

      6) Designed to include training and consultation, participation in team meetings and active involvement of the covered person's family and *treatment* team for implementation of the therapeutic goals developed by the team

   c. Concomitant services by a qualified therapist. We will cover services by a qualified therapist when all the following are true:

      1) The services are provided concomitant with intensive-level evidence-based behavioral therapy;

      2) You have a primary diagnosis of an autism spectrum disorder;

      3) You are actively receiving behavioral services from a qualified intensive-level provider or qualified intensive-level professional; and

      4) The qualified therapist develops and implements a treatment plan consistent with their license and this Section 9. F.

   d. Non-intensive-level services. You are eligible for non-intensive-level services, including direct or consultative services, that are evidence-based and are provided by a qualified provider, supervising provider, professional, therapist or paraprofessional under one of the following scenarios: (i) after the completion of intensive-level services, as long as the non-intensive-level services are designed to sustain and maximize gains made during the intensive-level *treatment*; or (ii) if you have not and will not receive intensive-level services but non-intensive-level services will improve your condition. Non-intensive-level services must be all of the following:

      1) Based upon a treatment plan and include specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that you be present and engaged in the intervention.

      2) Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law.

3) Provided in an environment most conducive to achieving the goals of your treatment plan.

4) Designed to provide training and consultation, participation in team meetings and active involvement of the *covered person's* family in order to implement therapeutic goals developed by the team.

5) Designed to provide supervision for qualified professionals and paraprofessionals in the *treatment* team.

6) Assessed and documented throughout the course of *treatment*. We may request and review your *treatment* plan and the summary of progress on a periodic basis.

2. Autism Services Exclusions:

This Section 9. F. is only subject to the following exclusions. The Plan provides no *benefits* for:

a. Acupuncture;

b. Animal-based therapy including hippotherapy;

c. Auditory integration training;

d. Chelation therapy;

e. Child care fees;

f. Cranial sacral therapy;

g. Hyperbaric oxygen therapy;

h. Custodial care or respite care;

i. Special diets or supplements;

j. Provider travel expenses;

k. Therapy, *treatment* or services when provided to a *covered person* who is residing in a residential treatment center, inpatient treatment or day treatment facility;

l. Costs for the facility or location or for the use of a facility or location when *treatment*, therapy or services are provided outside of your home;

m. Claims that have been determined by us to be fraudulent; and

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

G. Behavioral Health Services

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

1. Definitions. The following definitions apply to this Section 9. G. only:

a. **Collateral:** a member of your immediate family.

b. **Day Treatment Programs:** nonresidential programs for the *treatment* of *substance use disorders* and *nervous or mental disorders* that are operated by certified inpatient and outpatient Alcohol and Other Drug Abuse (AODA) facilities that provide case management, counseling, medical care and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week; also known as partial hospitalization.

c. **Hospital:** (1) a *hospital* licensed; (2) an approved private treatment facility; or (3) an approved public treatment facility.

d. **Inpatient Hospital Services:** services for the *treatment* of *nervous or mental disorders* or *substance use disorders* that are directly provided to a *covered person* who is a bed patient in a *hospital*. This definition does not include inpatient *hospital* services for detoxification associated with a *substance use disorder*. Please see Section 9. AA. (Covered Expenses / Hospital Services) for this coverage information.

e. **Outpatient Services:** nonresidential services for the *treatment* of *nervous or mental disorders* or *substance use disorders* directly provided to a *covered person* and, if for the purpose of enhancing his/her *treatment*, a *collateral* by any of the following: (a) a program in an outpatient treatment facility, if both the program and facility are approved by the Department of Health Services; (b) a licensed *physician* who has completed a residency in psychiatry, in an outpatient treatment facility or the *physician*'s office; (c) a *psychologist*; (d) a *licensed mental health professional* practicing within the scope of his/her license; or (e) a *health care practitioner* licensed to provide nonresidential services for the *treatment* of *nervous or mental disorders* or *substance use disorders* within the scope of that license.

f. **Residential Treatment Programs:** therapeutic programs for *treatment* of *nervous or mental disorders* and *substance use disorders*, including therapeutic communities and transitional facilities.

g. **Transitional Treatment:** services for the *treatment* of *nervous or mental disorders* and *substance use disorders* that are directly provided to you in a less restrictive manner than *inpatient hospital services* but in a more intensive manner than o*utpatient services*, if both the program and the facility are approved by the Department of Health Services. *Transitional treatment* includes any of the following *health care services* if provided by a *health care provider* certified by the Department of Health Services:

1) Mental health services for covered adults in a *day treatment program*;

2) Mental health services for covered *children* and adolescents in a *day treatment program*;

3) Services for *covered persons* with chronic mental *illness* provided through a community support program;

4) *Residential treatment programs* for *treatment* of a covered person's nervous or *mental disorders* and/or substance use disorders;

5) Services for *substance use disorders* provided in a *day treatment program*;

6) Intensive outpatient programs for substance use disorders and for *treatment of nervous or mental disorders*; and

7) Coordinated emergency mental health services which are provided by a *licensed mental health professional* for *covered 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.

Transitional treatment also includes out-of-state services and programs that are substantially similar to 1) through 7). above if the *health care provider* is in compliance with similar requirements of the state in which the *health care provider* is located.

2. **Covered Behavioral Health Services:**

a. Inpatient *hospital* services

b. Outpatient services; and

c. *Transitional treatment*

3. Covered Behavioral Health Services for Full-Time Students:

a. A *covered dependent* who is attending school outside of the *geographical service area*, but within Wisconsin, will have *benefits* available for limited *outpatient services* received from *non-participating providers* for *nervous or mental disorders* and *substance use disorders*.

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

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

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

e. 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.

4. Review Criteria for Transitional Treatment:

a. The criteria that we use to determine if a *transitional treatment* is *medically necessary* and covered under the Plan include, but are not limited to, whether:

1) The *transitional treatment* is certified by the Department of Health Services;

2) The *transitional treatment* meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;

3) The specific diagnosis is consistent with the symptoms;

4) The *transitional treatment* is standard medical practice and appropriate for the specific diagnosis;

5) The *transitional treatment* plan is focused for the specific diagnosis; and

6) The multidisciplinary team running the *transitional treatment* is under the supervision of a licensed psychiatrist practicing in the same state in which the *health care provider's* program is located or the service is provided.

b. We will need the following information from the *health care provider* to help us determine the *medical necessity* of a *transitional treatment*:

1) A summary of the development of your *illness* and previous *treatment*;

2) A well-defined *treatment* plan listing *treatment* objections, goals and duration of the care provided under the *transitional treatment* program; and

3) A list of credentials for the staff who participated in the *transitional treatment* program or service, unless the program or service is certified by the Department of Health Services.

5. Behavioral Health Services Exclusions:

The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

a. *Health care services* to treat academic problems not due to a clinically diagnosed *nervous or mental disorder*, or *health care services* a *child's* school is legally required to provide, whether or not the school actually provides them and whether or not a *covered person* chooses to use those services.

b. Behavioral *health care services* or *treatment* for, or in connection with, *developmental delays*. Please see Section 9. SS. (Covered Expenses / Therapy Services), which provides *benefits* for other *health care services* provided for or in connection with *developmental delays*.

c. *Treatment* of a behavioral or psychological problem that is not due to a clinically diagnosed *nervous or mental disorder*. Examples include occupational problems such as job dissatisfaction, antisocial behavior, parent-*child* problems such as impaired communication or inadequate discipline, marital problems, and other interpersonal problems.

d. *Health care services* provided by wilderness programs, boot camps, therapeutic boarding schools, and outward-bound programs.

e. Marriage counseling.

f. *Charges* for *health care services* provided to or received by a *covered person* as a *collateral* of a patient when those *health care services* do not enhance the *treatment* of another *covered person* under the Plan.

H. Blood and Blood Plasma

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

I. Cardiac Rehabilitation Services

1. **Covered Cardiac Rehabilitation Services**:

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

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

2. **Cardiac Rehabilitation Exclusions:**

   The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

   a. Cardiac rehabilitation beyond Phase II.

   b. Behavioral or vocational counseling.

J. Chiropractic Services

For therapy *benefits*, please see Section 9. SS. (Covered Expenses / Therapy Services).

1. **Covered Chiropractic Services**:

   Medically necessary services and diagnostic tests provided by a chiropractor.

2. **Chiropractic Services Exclusions:**

   The Plan provides no *benefits* for chiropractic services which are considered *maintenance care* or *supportive care*. This exclusion applies in addition to the exclusions outlined in Section 10. (General Exclusions).

K. Clinical Trials

1. **Definitions.** The following definitions apply to this Section 9. K. only:

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

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

Clinical trials may require prior authorization.
See www.aspirushealthplan.com

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

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

3) Fall under a covered benefit category and not excluded by law, regulation or current Medicare coverage guidelines;

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

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

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

c. **Qualifying Clinical Trial:** with respect to cancer or other *life-threatening conditions*, a *qualifying clinical trial* is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or *treatment* of cancer or other *life-threatening condition* and which meets any of the criteria in the bulleted list below.

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

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

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

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

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

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

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

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

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

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

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

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

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

d. **Routine Patient Care Costs:**

1) Include costs associated with any of the following:

a. *Health care services* that are typically covered under the Plan absent a clinical trial;

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

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

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

Do not include costs associated with any of the following:

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

a. Category B devices;

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

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

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

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

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

2. Benefits.

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

L. Cognitive Rehabilitation Therapy

Outpatient cognitive rehabilitation therapy following a brain *injury* or cerebral vascular accident. No other *benefits* are payable for cognitive rehabilitation therapy services.

M. Colorectal Cancer Screening and Diagnosis

Routine colorectal cancer screenings are covered as preventive screenings under Section 9. LL. (Covered Expenses / Preventive Care Services). Diagnostic colorectal cancer tests are covered under Section 9. Q. (Covered Expenses / Diagnostic Services) and Section 9. PP. (Covered Expenses / Surgical Services).

N. Contraceptives for Birth Control

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

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

Please note that oral contraceptives, contraceptive patches, diaphragms and contraceptive vaginal rings are covered under Section 9. KK. (Covered Expenses / Prescription Legend Drugs and Supplies) and male sterilization procedures are covered under Section 9. PP. (Covered Expenses / Surgical Services).

O. Dental Services

For *oral surgery benefits*, please see Section 9. PP. (Covered Expenses / Surgical Services).

1. **Covered Dental Services**:

   a. Dental repair or replacement of your *teeth* due to an *injury* if *treatment* begins within 90 days of the *injury*.

   b. Extraction of teeth: 1) in preparation of the jaw for radiation treatment of neoplastic disease; or 2) in preparation of a covered transplant.

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

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

      1) You are a *child* under the age of five;

      2) You have a chronic disability that meets all of the following:

         a) Is attributable to a mental or physical impairment or combination of mental and physical impairments;

         b) Is likely to continue indefinitely; and

         c) Results in substantial limitations as determined by us in one or more of the following areas: self-care, receptive and expressive language, learning, mobility; capacity for independent living, and economic self-sufficiency; or

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

2. **Dental Services Exclusions:**

   The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

   a. The general dental care and *treatment* of teeth, gums, or alveolar process including dentures, appliances, or *supplies* used in such care or *treatment*.

   b. *Injuries* or damage to teeth (natural or otherwise) caused by chewing food or similar substances.

   c. Dental implants or other implant-related procedures.

   d. Orthodontic *treatment* (e.g. braces).

   e. Tooth extraction of any kind, except as specifically stated in Paragraph 2. above.

f. Periodontal care.

P. Diabetes Services

1. Covered Diabetes Services:

a. Purchase and installation of up to one insulin infusion pump per *covered person* per *calendar year*.

b. Continuous glucose monitor.

c. All other equipment and *supplies* used in the *treatment* of diabetes when they are dispensed by a *health care provider* other than a pharmacy. When insulin syringes and needles, lancets and lancet devices, diabetic test strips, alcohol pads, blood glucose monitors, auto injectors, and glucose control solution are dispensed by a pharmacy, *benefits* are payable according to Section 9. KK. (Covered Expenses / Prescription Legend Drugs and Supplies).

d. Medical eye exams (dilated retinal examinations).

e. Preventive foot care for *covered persons* with diabetes.

f. Diabetic self-management education programs.

g. Diabetic shoes when *medically necessary*.

2. Diabetes Services Limitation:

Insulin is not covered under this Section 9. P. For coverage of insulin, see Section 9. KK. (Covered Expenses / Prescription Legend Drugs and Supplies).

3. Diabetes Services Exclusion:

The Plan provides no *benefit* for the replacement of equipment unless *medically necessary* as determined by us. This exclusion applies in addition to the exclusions outlined in Section 10. (General Exclusions).

Q. Diagnostic Services

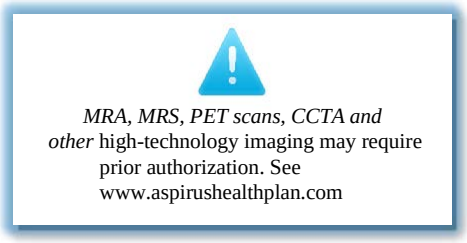
See Section 9. U. (Covered Expenses / Genetic Services) for *benefits* for genetic services.

1. Covered Diagnostic Services:

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

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

b. Laboratory services.



2. Diagnostic Services Exclusions:

The Plan provides no *benefits* for any of the items listed below.
These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

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

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

R. Drug Abuse Treatment

See Section 9. G. (Covered Expenses / Behavioral Health Services) for *benefits* for the *treatment* of *substance use disorders*.

S. Durable Medical Equipment

1. Covered Durable Medical Equipment:

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

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

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

d. Breastfeeding equipment in conjunction with each birth.

2. Durable Medical Equipment Limitations:

a. *Benefits* will be limited to the standard models, as determined by us.

b. We will pay *benefits* for only one of the following: a manual wheelchair, a motorized wheelchair, a knee walker, or a motorized scooter, as determined by us.

3. Durable Medical Equipment Exclusions:

The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

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

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

c. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs, and cryotherapy; and home automated external defibrillator (AED).

d. *Durable medical equipment* that we determine to have special features that are not *medically necessary*.

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

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

g. Replacement of equipment unless we determine that it is *medically necessary*.

h. Replacement of over-the-counter batteries.

i. Repairs due to abuse or misuse as determined by us.

j. Devices and computers to assist in communication and speech.

k. Enuresis alarms.

T. Emergency Medical Care

1. Covered Emergency Medical Care:

a. *Emergency medical care* in an emergency room, as described below:

1) *Benefits* are payable for *health care services* provided in an emergency room as shown in the Schedule of Benefits. If a *copayment* is shown, this *copayment* applies to the *emergency room*

visit. We will waive the *emergency room visit copayment* if you are admitted as a resident patient to the *hospital* directly from the emergency room. If you are placed in *observation care* directly from the emergency room, the *emergency room visit copayment*, if applicable, will not be waived.

2) If you are admitted as a resident patient to the *hospital* directly from the *hospital* emergency room, *charges* for *covered expenses* provided in the *hospital* emergency room will be payable as stated in the Schedule of Benefits which applies to that *hospital confinement*.

3) If you are outside of the *geographical service area* and a *medical emergency* arises that requires you to go to an emergency room, you are eligible for coverage regardless of which emergency room you use.

b. *Emergency medical care* received in a *health care practitioner's* office, *urgent care* facility, or any place of service other than an emergency room will be payable as shown in the Schedule of Benefits.

2. Emergency Medical Care Limitations:

a. If follow-up care or additional *health care services* are needed after the *medical emergency* has passed, you will need our *prior authorization* before receiving such services from a *non-participating provider* if you want those *health care services* to be paid at the *participating provider* level of benefits.

b. Covered *health care services* received from a *non-participating provider* will be limited to the amounts that we determine to be the *out-of-network usual and customary amount*. You will be responsible for the difference between the amount *charged* and the *out-of-network usual and customary amount.*

c. If an *ambulance service* is called and you are transported to an emergency room, coverage for any *emergency medical care* directly provided to you during your ambulance transport is payable under Section 9. D. (Covered Expenses / Ambulance Services*)*. If an *ambulance service* is called, but you are not transported, *emergency medical care* provided to you will be payable under this Section 9. T., as shown in the Schedule of Benefits.

U. Genetic Services

Certain genetic services may require prior authorization. See www.aspirushealthplan.com

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

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

1. Covered Genetic Services:

a. Genetic counseling provided to you by a *health care practitioner*, a licensed or Master's trained genetic counselor or a medical geneticist;

b. Amniocentesis during pregnancy;

c. Chorionic villus sampling for *genetic testing* and non-*genetic testing* during pregnancy;

d. Identification of infectious agents such as influenza and hepatitis. Panel testing for multiple agents is not covered unless your *health care practitioner* provides a justification for including each test in the panel;

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

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

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

h. BRCA testing for a *covered person* whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations and testing has been recommended after receiving genetic counseling. When such genetic counseling and testing is provided by a *participating provider*, *benefits* are payable without cost-sharing; and

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

2. Genetic Services Exclusions:

The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

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

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

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

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

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

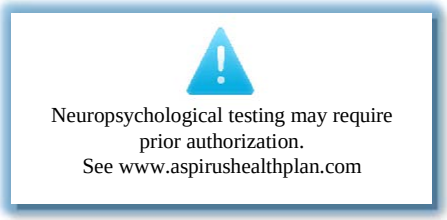
V. Health and Behavior Assessments

1. Covered Health and Behavior Assessments:

a. Health and behavior assessments and reassessments;

b. Diagnostic interviews;

c. Neuropsychological testing.



Please note that health and behavioral interventions provided by a *psychologist* pursuant to a health and behavior assessment are covered under Section 9. EE. (Covered Expenses / Medical Services).

2. Health and Behavior Assessments Exclusions:

The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

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

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

W. Hearing Aids, Implantable Hearing Devices, and Related Treatment

1. **Definitions**:

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

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

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

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

2. **Covered Hearing Services:**

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

   a. One *hearing aid* (including fitting and testing), per ear, per *covered dependent child* under age 18 once every three years;

   b. One *cochlear implant* per ear, per *covered dependent* age 18 or older, limited to one per lifetime.

   c. *Implantable hearing devices*;

   d. *Treatment* related to *hearing aids* and *implantable hearing devices* covered under this Subsection 2., including procedures for the implantation of *implantable hearing devices.*

   e. Post-*cochlear implant* aural therapy.

3. **Hearing Services Exclusions:**

   The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

   a. Hearing protection equipment.

   b. *Hearing aid* batteries and cords.

X. Home Care Services

This Section 9. X. applies only if *charges* for *home care* services are not covered elsewhere under the Plan.

1. **Definitions:**

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

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

2. **Covered Home Care Services:**

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

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

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

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

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

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

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

3. **Home Care Limitations:**

   a. *Benefits* are limited to 40 *home care* visits per *covered person* per *calendar year*. Each visit by a person to provide services under a *home care* plan, to evaluate your need for *home care*, or to develop a *home care* plan counts as one *home care* visit. Each period of up to four straight hours of *home health aide services* in a 24-hour period counts as one *home care* visit

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

4. **Home Care Exclusions:**

   The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

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

   b. *Home care* provided to a *covered person* who is not confined to his/her home because of an *illness* or *injury*, or because leaving his/her home would be contraindicated.

Y. Home Intravenous (IV) Therapy or Infusion Therapy

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

Home infusion services may require prior authorization. See www.aspirushealthplan.com

Z. Hospice Care

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

symptom management, and medical support services. *Hospice care* may be provided at hospice facilities or in your place of residence.

2. **Covered Hospice Care Services**:

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

   b. Covered expenses for *hospice care* include:

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

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

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

   c. We will pay *benefits* for *charges* for *covered expenses* for *hospice care* services provided to you during the initial six-month period immediately following the diagnosis of a terminal *illness*. Coverage for *hospice care* services after the initial six-month period will be extended by us under the Plan beyond the initial six-month period, provided, a *health care practitioner* certifies in writing that you are terminally ill.

3. **Hospice Care Services Exclusions:**

   The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

   a. Room and board for residential care at a *hospital* facility.

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

AA. Hospital Services

Transplant services are not covered under this Section 9. AA.; please see Section 9. TT. (Covered Expenses / Transplants) for this coverage information. This Section 9. AA. does not include *charges* for outpatient physical, speech, or occupational therapy; please see Section 9. SS. (Covered Expenses / Therapy Services). Additionally, except for inpatient *hospital* services for detoxification, services for the *treatment* of *substance use disorders* and/or *nervous or mental disorders* are not covered under this Section 9. AA.; please see Section 9. G. (Covered Expenses / Behavioral Health Services) for these coverage details.

1. **Covered Hospital Services:**

   a. **Inpatient Hospital Services.** *Benefits* are payable for the following inpatient *hospital* services for a *physical illness* or *injury*:

      1) *Charges* for room and board;

      2) *Charges* for nursing services;

      3) *Charges* for miscellaneous *hospital* expenses; and

      4) *Charges* for intensive care unit room and board.

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

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

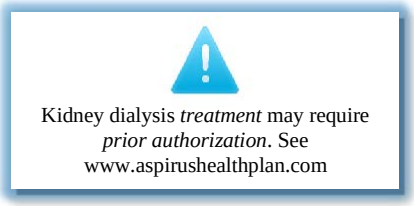
2. **Hospital Services Limitations:**

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

   b. If you are stable and refuse such transfer, further services from the *non-participating provider* will not be covered at the *participating provider* level of benefits.

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

BB. Kidney Disease Treatment



Dialysis *treatment*, including any related *medical supplies* and laboratory services provided during dialysis and billed by the outpatient department of a *hospital* or a dialysis center.

Kidney transplantation services are payable under the organ transplant *benefit* in Section 9. TT. (Transplants).

CC. Mastectomy Treatment

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

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

DD. Maternity Services

1. **Covered Maternity Services:**

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

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

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

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

      4) Health care services for miscarriages.

      5) *Health care services* related to an elective abortion.

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

2. Maternity Exclusions:

The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

a. Birthing classes, including Lamaze classes.

b. Home births.

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

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

EE. Medical Services

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

2. *Medical services* for a *physical illness* or *injury*, including second opinions. Services must be provided in a *hospital*, *health care practitioner's* office, *urgent care* center, surgical care center, *convenient care clinic*, or your home. *Medical services* covered under this Section 9. EE. do not include *health care services* covered elsewhere in the Plan, including *home care* services covered under Section 9. X. (Covered Expenses / Home Care Services).

FF. Medical Supplies

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

a. Strapping and crutches;

b. Ostomy *supplies* limited to the following: pouches, face plates and belts; irrigation sleeves, bags and ostomy irrigation catheters; and skin barriers;

c. Disposable *supplies*, tubing, and masks for the effective use of covered *durable medical equipment;*

d. Elastic stockings or supports when prescribed by a *health care practitioner* and required in the treatment of an *illness* or *injury*. We may establish reasonable limits on the number of pairs allowed per covered person per calendar year;

e. Enteral therapy supplies; and

f. Urinary catheters and supplies.

2. Medical Supplies Exclusions:

The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

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

b. Ostomy *supplies* that are not listed in Paragraph 1. above (such as deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover).

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

GG. Nutritional Counseling

Nutritional counseling that is: (1) for *treatment* of an *illness* or *injury*; and (2) provided by a *health care practitioner*, dietician or nutritionist licensed in the state where the counseling is provided to you. Nutritional counseling billed as educational services will not be covered, except as noted in Section 9. LL. (Covered Expenses / Preventive Care Services).

HH. Orthotic Devices and Appliances

1. **Covered Orthotic Devices and Appliances:**

   a. Externally applied devices or appliances, including fittings and adjustments of custom-made rigid or semi-rigid supportive devices, that: (i) are used to support, align, prevent, or correct deformities; (ii) improve the function of movable parts of the body; or (iii) limit or stop motion of a weak or diseased body part.

   b. Covered orthotic devices and appliances include, but are not limited to:

   1) Casts and splints;

   2) Orthopedic braces, including necessary adjustments to shoes to accommodate braces;

   3) Cervical collars; and

   4) Corsets (back and special surgical).

   c. Orthotic devices or appliances to support the foot when they are a permanent part of an orthopedic leg brace or when custom-molded to fit the *covered person*.

   d. Orthopedic shoes limited to one pair per *covered person* per calendar year.

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

2. Orthotic Devices and Appliances Limitation:

   Benefits will be limited to the standard models, as determined by us.

3. **Orthotic Devices and Appliances Exclusions:**

   The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

   a. Routine periodic maintenance, such as testing, cleaning and checking of the device or appliance.

   b. Cranial banding or orthotic helmets, unless required after cranial surgery.

   c. Over-the-counter orthotic devices and appliances to support the foot.

II. Pain Management Treatment

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

JJ. Palliative Care Services

1. **Definition of Palliative Care:** care that optimizes quality of life for people with serious *illness* by anticipating, preventing, and treating their suffering. *Palliative care* may be provided throughout the continuum of *illness*. It generally involves

addressing physical, emotional, and social needs and facilitating patient autonomy, access to information, and choice.

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

KK. Prescription Legend Drugs and Supplies

1. **Definitions.** The following definitions apply to this Section 9. KK. only:

   a. **Biosimilar(s):** a *prescription legend drug* of biological origin developed such that there are no clinically meaningful differences between the biological product and its FDA-approved reference product in terms of safety, purity, and potency, and demonstrates similarity to the reference product in terms of quality characteristics, biological activity, safety and efficacy. A *biosimilar* may be classified as a *brand-name drug*, *generic drug*, and /or *specialty drug*.

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

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

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

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

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

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

   h. **Preventive Drug(s):** drugs that we are currently required by law to define as preventive drugs include: (1) aspirin for the prevention of cardiovascular disease (age 50-59) and after 12 weeks of gestation in women who are at high risk for preeclampsia; (2) fluoride supplements if you are older than six months but younger than 17 years old; (3) folic acid for women planning or capable of pregnancy; (4) oral contraceptives, contraceptive patches, contraceptive devices (e.g., diaphragms, sponges, gel) and contraceptive vaginal rings for birth control; (5) nicotine replacements (e.g., patches and gum) and covered drugs used for smoking cessation if you are age 18 and over; (6) risk reducing medications, such as tamoxifen or raloxifene, for women who are at increased risk for breast cancer and at low risk for adverse medication effects; (7) immunizations; (8) low/moderate dose statins for ages 40-75 with at least one cardiovascular disease risk factor and a 10-year calculated risk of at least 10%; (9) bowel preparations related to a preventive colonoscopy; and (10) Preexposure prophylaxis (PrEP) antiretroviral therapy for *covered persons* at high risk of HIV acquisition. The USPSTF may change the definition of *preventive drugs* during the course of the year. The USPSTF may change the definition of *preventive drugs* during the course of the year. Please see www.uspreventiveservicestaskforce.org.

i. **Specialty Drug(s):** *prescription legend drugs* that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost. To determine if a drug is a specialty drug and if that specialty drug requires our *prior authorization*, visit our website at www.aspirushealthplan.com or call the telephone number shown on your identification card.

j. **Specialty Pharmacy:** a *participating pharmacy* designated by us to dispense *specialty drugs*. To locate a *specialty pharmacy*, contact us by calling the telephone number shown on your identification card or visit the website of the pharmacy benefit manager listed on your identification card.

2. **Covered Drugs.**

a. Any *prescription legend drug* not otherwise excluded or limited under the Plan;

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

c. *Preventive drugs that* are obtained pursuant to a *prescription order;*

d. Injectable insulin;

e. *Prescription legend drugs* that are FDA-approved for the *treatment* of HIV infection or an *illness* or medical condition arising from, or related to, HIV;

f. An immunization that is not excluded elsewhere in the Plan;

g. Oral chemotherapy drugs; and

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

3. **Covered Supplies.**

a. Insulin syringes and needles;

b. Lancets and lancet devices;

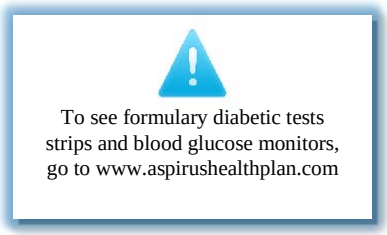
c. Formulary diabetic test strips;

d. Alcohol pads;

e. Formulary blood glucose monitors;

f. Auto injector;

g. Glucose control solution.



4. **Our Discretion.** We have full discretionary authority to cover drugs or *supplies* that vary from the *benefits* described in the Plan if there is an advantage to both you and us.

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

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

a. **Participating Pharmacies.** *Benefits* are generally not payable for covered drugs and *supplies* dispensed to you by someone other than a *participating pharmacy*, *home delivery pharmacy*, or *specialty pharmacy*. We will, however, reimburse you for any covered drugs and *supplies* you receive during a *medical emergency* outside of the *geographical service area*. In this situation, you must pay for the covered drugs or *supplies* up front. Then you must send us a claim for reimbursement. To receive reimbursement you must send us, or our *delegate*, a claim with written proof of payment and enough detail to allow us to process the claim. After we receive your claim and supporting documentation, we will determine if *benefits* are payable for the drug or *supply*. If so, we will pay you the *benefit* amount that we would have paid had you purchased the covered drug or *supply* from a *participating pharmacy*. You are responsible for the applicable *copayment*, *deductible*, or *coinsurance*, and any difference between our *benefit* payment and the price you paid for the covered drug or *supply*.

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

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

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

After receiving the required information, we, or our *delegate*, will determine if the drug is covered under the Plan and notify you of our coverage determination. If we determine that the *treatment* is not a covered drug or is otherwise excluded under the Plan, no *benefits* will be payable for that drug.

d. **Use of Brand-Name Drugs When Lower Cost Equivalents Are Available.** If you obtain a *brand-name drug* and we determine that a lower cost equivalent drug (e.g. *generic drug* or *biosimilar* is available, you must pay the difference in cost between the drug obtained and its equivalent, plus the applicable *copayment*/*deductible*/*coinsurance* amount, unless your physician specifically instructs to dispense the drug "as written.' The cost difference is not applied toward your *out-of-pocket limit*. Determination that a drug is equivalent must be supported by scientific evidence and/or determinations by regulatory entities such as the FDA.

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

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

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

Item	Quantity Limit
Prescription legend drugs or *supplies* dispensed by a *participating pharmacy*	90-day supply per fill or refill
Prescription legend drugs (other than *specialty drugs*) or *supplies* dispensed by a *home delivery pharmacy*	90-day supply per fill or refill
Preventive drugs used for Tobacco Cessation	180-day supply of nicotine replacement *treatment* (*e.g.*, patches or gum) per *covered person* per 365 day period; and 180-day supply of another type of covered tobacco cessation drug (*e.g.*, varenicline or bupropion) per *covered person* per 365 day period
Specialty drugs	30-day supply per fill or refill, except as noted above
Blood glucose monitor dispensed by a *participating pharmacy*	One per *covered person* per *calendar year*
Prescription legend drugs to treat sexual dysfunction	8 pills per month

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

g. **Miscellaneous:** If the *charges* for a *prescription legend drug* is reduced by a manufacturer promotion (e.g., a coupon or rebate), we may take that reduction into account when calculating the cost-sharing, including the amount applied to your *deductible* or *out-of-pocket limit*.

7. Prescription Legend Drugs and Supplies Exclusions.

The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

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

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

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

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

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

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

g. Anabolic drugs, unless we determine that they are being used for accepted medical purposes and eligible for coverage under the Plan;

h. Progesterone or similar drugs in any compounded dosage form, except for the purpose of maintaining a pregnancy under the appropriate standard of care guidelines;

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

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

k. Any drug or medicine that is available in prescription strength without a *prescription order*, except as determined by us;

l. More than one fill or refill for the same covered supply, covered drug or therapeutic equivalent medication prescribed by one or more *health care practitioner* until you have used at least 75% of the previous retail prescription. If the covered supply, drug or therapeutic equivalent medication is dispensed by a *home delivery pharmacy*, then you must have used at least 75% of the previous prescription;

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

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

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

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

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

r. Drugs dispensed by a person or entity other than a *participating pharmacy*, *home delivery pharmacy*, or *specialty pharmacy*, except for emergencies outside of the *geographical service area*;

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

t. All medicinal foods, enteral feedings, supplemental feedings, nutritional and electrolyte supplements, and infant formula;

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

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

LL. Preventive Care Services

The following *preventive care services* are covered to the extent required by law. There is no cost sharing for *preventive care services* provided by a *participating provider*.

1. Covered Preventive Care Services:

a. Evidence-based *health care services* that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). The USPSTF may change its ratings during the year. See https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ for the current recommendations. Currently, the recommendations include:

1) Routine medical exams, including eye exams with or without refractions, hearing exams, pelvic exams, pap smears, and any related *preventive care services*. Pelvic exams and pap smears are covered under this Paragraph 1. when directly provided to you by a *health care practitioner*

2) Routine medical exams, including eye exams with or without refractions, hearing exams, and any related *preventive care services* directly provided to a covered *child* in connection with well-*child* care.

3) One routine mammogram of a *covered person* per *calendar year*.

4) Blood lead tests;

5) Preventive screenings;

6) Behavioral interventions to promote breast feeding; comprehensive lactation support and counseling by a trained *health care provider* during pregnancy and/or in the postpartum period;

7) Annual counseling on sexually transmitted infections;

8) Counseling for tobacco use;

9) Prophylactic ocular topical medication for newborns against gonococcal ophthalmia neonatorum;

10) Annual screening and counseling for *covered persons* for interpersonal and domestic violence;

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

12) Behavioral counseling for skin cancer.

b. Other *preventive care services* that are provided on an outpatient basis at a *health care practitioner's* office or *hospital* and that have been: demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease; and proven to have a beneficial effect on health outcomes. Such covered *preventive care services* include, but are not limited to, the following:

1) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, including travel immunizations;

2) With respect to infants, *children* and adolescents, evidence-informed *preventive care services* and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

3) With respect to women, such additional *preventive care services* and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

c. Screening for colorectal cancer, including fecal occult blood testing, limited to routine sigmoidoscopy or colonoscopy, including related *health care services*, in accordance with the most current guidelines of the USPSTF.

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

2. Preventive Care Services Limitation:

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

MM. Prosthetics

1. Covered Prosthetics:

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

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

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

Prosthetics with a total purchase price greater than $5,000 may require prior authorization. See www.aspirushealthplan.com

Covered prosthetic devices include, but are not limited to, artificial limbs, eyes, and larynx. *Benefits* are limited to one purchase no sooner than every three years of each type of the standard model, as determined by us.

b. Replacement or repairs of prosthetics if we determine that they are *medically necessary*.

2. **Prosthetics Exclusions**:

This Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

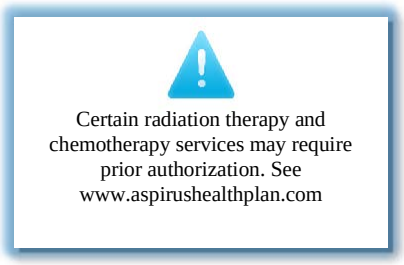
a. Prosthetics that we determine to have special features that are not *medically necessary*.

b. Dental prosthetics.

c. Repairs due to abuse or misuse.

NN. Radiation Therapy and Chemotherapy Services

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



OO. Skilled Nursing Care in a Skilled Nursing Facility

1. **Covered Skilled Nursing Care:**

a. *Skilled nursing care* provided to you during the first 30 days of your *confinement* in a *skilled nursing facility* if: (1) you are admitted to a *skilled nursing facility* within 24 hours after discharge from a *hospital* or surgical center or directly from emergency room care, urgent care facility, or a *health care practitioner*'s office; and (2) you are admitted for continued *treatment* of the same *illness* or *injury*.

b. Each day of your *confinement* will count towards this 30-day limit, regardless of whether the *charges* are applied to your *deductible* or paid by Aspirus Health Plan, Inc. under the Plan.

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

2. **Skilled Nursing Care Exclusions:**

This Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

a. *Skilled nursing care* during a *skilled nursing facility confinement* if *health care services* can be provided at a lower level of care (*e.g. home care*, as defined in Section 9. X. (Covered Expenses /Home Care Services), or care in an outpatient setting).

b. Domiciliary care, such as meals-on-wheels, health visiting, and home help, provided by a welfare agency for people in their own homes.

c. *Maintenance care*, *supportive care*, or *custodial care*.

d. Care that is available at no cost to you or care provided under a governmental health care program (other than a program provided).

PP. Surgical Services

This Section 9. PP. does not include *surgical services* for: (1) covered transplants; (2) pain management procedures; or (3) *behavioral health services*. Please see Section 9. G. (Covered Expenses / Behavioral Health Services), Section 9. II. (Covered Expenses / Pain Management Treatment), and Section 9. TT. (Covered Expenses / Transplants) for this coverage information.

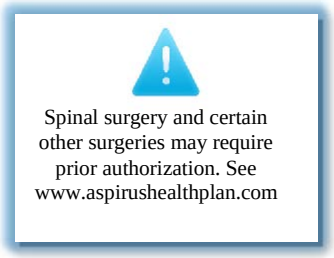
1. **Definitions:**

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

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

2. **Covered Surgical Services:**

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

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

      1) Operative and cutting procedures;

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

      3) Other invasive procedures such as: (a) angiogram; and (b) arteriogram.

   b. *Reconstructive surgery* when the primary purpose of the surgery is to correct *functional impairment* caused by an *illness*, *injury*, congenital abnormality, acute traumatic *injury*, dislocation, tumors, cancer, obstructive sleep apnea, or temporomandibular joint disorder. Please note that breast reconstruction following a mastectomy, reconstruction of the non-affected breast to achieve symmetry, and other services required by the Women's Health and Cancer Rights Act of 1998 are covered under Section 9.CC. (Covered Expenses / Mastectomy Treatment).

   c. *Oral surgery*, including related consultation, x-rays and anesthesia, is limited to the following procedures:

      1) Surgical removal of impacted, unerupted teeth

      2) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

      3) Surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;

      4) Apicoectomy (excision of the apex of the tooth root);

      5) Root canal therapy, if performed simultaneously with an apicoectomy;

      6) Excision of exostosis (bony outgrowth) of the jaws and hard palate;

      7) Frenotomy (incision of the membrane connecting the tongue to the floor of the mouth);

      8) Incision and drainage of cellulitis (tissue inflammation) of the mouth;

      9) Incision of accessory sinuses, salivary glands or ducts;

      10) Gingivectomy (excision of gum tissue to eliminate infection), but not including restoration of gum tissue or soft tissue;

      11) Alveolectomy (if not performed in conjunction with routine extraction of natural teeth);

      12) Reduction of fractures and dislocations of the jaw; and

      13) Orthognathic surgery.

   d. Male sterilization procedures.

   e. Tissue transplants (*e.g.*, arteries or veins, corneas, heart valves, skin) placed in the body to aid the function of a body organ or replace tissue lost due to *illness* or *injury*.

f. Congenital heart disease surgeries.

g. Removal of breast implants due to association with Anaplastic Cell Lymphoma.

3. Surgical Services Exclusions:

This Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

a. *Incidental/inclusive* surgical procedures that are performed in the same operative session as a major covered surgical procedure, which is the primary procedure. *Benefits* for *incidental/inclusive* surgical procedures are limited to the *charge* for the primary surgical procedure with the highest *charge*, as determined by us. No additional *benefits* are payable for *incidental/inclusive* surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an *incidental/inclusive* surgical procedure; therefore, *benefits* are payable for the hysterectomy, but not for the removal of the appendix.

b. Reversal of a sterilization procedure.

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

d. *Reconstructive surgery* for purposes other than to correct those *functional impairment*.

e. Any *surgical service* that we determine to be *cosmetic treatment*, except as otherwise indicated in the Plan.

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

g. Alveolectomy performed in conjunction with routine extraction of natural teeth.

QQ. Telemedicine

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

2. Covered Telemedicine Services:

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

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

3. Telemedicine Exclusions:

This Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

a. Transmission fees.

b. Website charges for online patient education material.

RR. Temporomandibular Joint (TMJ) Disorder Services

1. Covered TMJ Disorder Services:

a. Diagnostic procedures and surgical and non-surgical *treatment* for the correction of TMJ disorders if all of the following apply:

1) The disorder is caused by congenital, developmental or acquired deformity, *illness* or *injury*;

2) Under the accepted standards of the profession of the *health care practitioner* providing the service, the procedure is reasonable and appropriate for the diagnosis or *treatment* of the condition; and

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

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

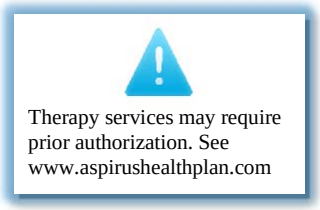
2. TMJ Disorder Services Exclusions:

This Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

a. Elective orthodontic care, periodontic care, or general dental care.

b. *Health care services* provided in connection with the temporomandibular joint or TMJ disorder, except as specifically stated in Paragraph 1. above.

SS. Therapy Services



1. Definitions:

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

b. **Rehabilitative Services:** *health care services* that help a person keep, get back or improve skills and functioning for *activities of daily living* that have been lost or impaired because a person had an *illness*, *injury*, or was disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

2. Therapy Limitations:

a. Outpatient therapy is limited as follows:

1) Physical therapy is covered when billed as *rehabilitative services* or *habilitative services*. Massage therapy is covered only when the therapy is billed by a chiropractor, physical therapist or occupational therapist. Aquatic therapy is covered only when billed by a physical therapist or occupational therapist;

2) Speech therapy is covered when billed as *rehabilitative services* or as *habilitative services*; and

3) Occupational therapy is covered when billed as *rehabilitative services* or as *habilitative services.*

b. All therapy must be expected to provide significant measurable gains that will improve your physical health.

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

3. Therapy Exclusions:

This Plan provides no *benefit* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

a. Physical therapy for TMJ disorders, except as specifically stated in Section 9. RR. (Covered Expenses / Temporomandibular Joint (TMJ) Disorder Services).

b. Long-term therapy and maintenance therapy, except as specifically stated in Paragraph 2. above.

TT. Transplants

1. Definitions. The following definitions apply to this Section 9. TT. only:

a. **Covered Transplant Drugs:** immunosuppressant drugs prescribed by a *physician* when dispensed by a *health care provider* while you are not *confined* in a *hospital*. These drugs do not include high dose chemotherapy, except for high dose chemotherapy provided for a covered bone marrow transplant. This includes refills of immunosuppressant drugs.

b. **Designated Transplant Facility:** a facility that is (i) approved by us to be the most appropriate facility for your approved *transplant services*; (ii) contracted to provide approved *transplant services* to *covered persons* pursuant to an agreement with one of our transplant provider networks.

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

d. **Transplant Services:** approved *health care services* for which a *prior authorization* has been received and approved for transplants when ordered by a *physician*. Such services include, but are not limited to, *hospital charges*, *health care practitioner's charges*, *organ and tissue acquisition*, tissue typing, and ancillary services.

2. Prior Authorization and Cost-Sharing Requirements:

a. All *transplant services* require *prior authorization*. It is your responsibility to obtain a *prior authorization* for all transplant related services, including but not limited to the initial transplant evaluation. The transplant must meet our criteria for *medically necessary* transplants and may not be *experimental/investigational/unproven*.

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

c. Transplant *benefits* are subject to any *deductibles* and *coinsurance* amounts shown in the Schedule of Benefits.

3. Covered Transplants:

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

b. Covered expenses for transplant services include health care services for approved transplants when ordered by a *physician*. Health care services include, but are not limited to, hospital charges, physician charges, organ and tissue acquisition, tissue typing, and ancillary services. Covered transplant drugs are payable as described in Section 9. KK. (Covered Expenses / Prescription Legend Drugs and Supplies).

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

1) Kidney;

2) Kidney/pancreas;

3) Liver;

4) Heart;

5) Heart/lung;

6) Lung;

7) Bone marrow (allogenic and autologous)

8) Stem cell transplants

9) Small bowel transplantation;

10) Cornea; and

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

d. We will notify you if a second opinion is required at any time during the determination of benefits period. If you are denied a transplant procedure by the *designated transplant facility*, we will refer you to a second *designated transplant facility* for evaluation. If the second facility determines, for any reason, that you are 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-d*esignated transplant facility* accepts you for the procedure.

4. Transplant Exclusions:

This Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

a. Transplants considered by us to be experimental/investigational/unproven.

b. Expenses related to the purchase of any organ.

c. *Health care services* for, or used in connection with, transplants of human and non-human body parts, tissues or substances, or implants of artificial or natural organs, except as specifically stated in Paragraph 3. Above; and

d. Lodging expenses, including travel and meals.

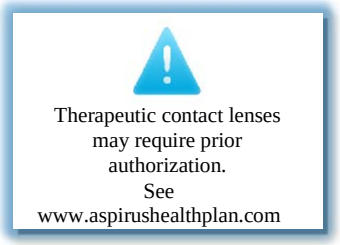
UU. Vision Services - Non-Routine

1. Covered Non-Routine Vision Services:

a. Diagnosis and *treatment* of eye pathology.

b. Eye surgery to treat an *illness* or *injury* to the eye.

c. Initial pair of eyeglasses or external contact lenses for aphakia, keratoconus, or following cataract surgery.



2. Vision Services Exclusions:

The Plan provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 10. (General Exclusions).

a. Vision therapy;

b. Refractive eye surgery, such as radial keratotomy.

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

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

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

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

10. GENERAL EXCLUSIONS

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

1. Health care services that we determine are not medically necessary.

2. *Health care services* that we determine are *experimental/investigational/unproven*, except for the following, which are covered under the Plan as described in Section 9. KK. (Covered Expenses / Prescription Legend Drugs and Supplies):

a. Investigational drugs for the *treatment* of HIV infection; and

b. Drugs that by law require a written prescription used in the *treatment* of cancer that may not currently have the FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate *treatment* for that diagnosis.

3. *Maintenance care* or *supportive care*.

4. *Health care services* that we determine to be *cosmetic treatment*, except as otherwise provided in the Plan.

5. *Health care services* provided in connection with any *injury* or *illness* arising out, or sustained in the course, of any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance. This exclusion applies regardless of whether benefits under workers' compensation laws or any similar laws have been claimed, paid, waived, or compromised. See Section 15. I. (Workers' Compensation) for additional information.

6. *Health care services* furnished by the U.S. Veterans Administration, unless federal law designates the Plan as the primary payer and the U.S. Veterans Administration as the secondary payer.

7. *Health care services* furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless such coverage under the Plan is required by law.

8. The amount of *benefits* that are covered by, or would be covered by, Medicare as the primary payer if you are eligible for Medicare. This applies regardless of whether you are actually enrolled in Medicare. See Section 11. H. (Coordination of Benefits / Coverage with Medicare) for additional information.

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

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

11. *Custodial care*, except *home health aide services* as covered in Section 9. X. (Covered Expenses / Home Care Services).

12. *Charges* in excess of the *usual and customary amount* or *out-of-network usual and customary amount*.

13. Chelation therapy, except in the *treatment* of heavy metal poisoning.

14. *Health care services* provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in custody of law enforcement officials, except as required. This exclusion does not apply to *covered persons* on work-release.

15. Completion of forms, including but not limited to claim forms or forms necessary for the return to work or school.

16. An appointment you did not attend.

17. *Health care services* for which you have no obligation to pay or which are provided to you at no cost.

18. *Health care services* resulting or arising from complications of, or incidental to, any *health care service* not covered under the Plan, except from complications of, or incidental to, a *subscriber*'s or his/her spouse's elective abortion.

19. *Health care services* requested or required by a third party for employment, licensing, insurance, marriage, adoption, travel, disability determinations, or court-ordered exams, other than as specifically stated in the Plan or required by law.

20. Private duty nursing.

21. Transportation or other travel costs associated with a *health care service*, except as specifically provided in Section 9. D. (Covered Expenses / Ambulance Services).

22. *Health care services* that are excluded elsewhere in the Plan.

23. *Health care services* not specifically identified as being covered under the Plan, except for those *health care services* approved by us subject to Section 9. C. (Covered Expenses / Alternative Care).

24. *Health care services* provided when your coverage was not effective under the Plan. Please see Section 6. (Eligibility, Enrollment, and Effective Date) and Section 12. (When Coverage Ends).

25. *Health care services* not provided by a *health care practitioner* or any of the *health care providers* listed in Section 9. (Covered Expenses).

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

- **a.** Injection of filling material (collagen) other than for incontinence;
- **b.** Salabrasion;
- **c.** Rhytidectomy (face lift);
- **d.** Dermabrasion;
- **e.** Chemical peel;
- **f.** Suction-assisted lipectomy (liposuction);
- **g.** Hair removal;
- **h.** Mastopexy;
- **i.** Augmentation mammoplasty (except for reconstruction associated with a covered mastectomy);
- **j.** Correction of inverted nipples;
- **k.** Sclerotherapy or other *treatment* for varicose veins less than 3.5 millimeters in size (*e.g.* telangiectasias, spider veins, reticular veins);
- **l.** Excision or elimination of hanging skin on any part of the body, such as panniculectomy; abdominoplasty and brachioplasty;
- **m.** Mastectomy for gynecomastia
- **n.** Botulinum toxin or similar products, unless you receive our *prior authorization* approval;
- **o.** Any modification to the anatomic structure of a body part that does not affect its function;
- **p.** Labiaplasty;

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

27. *Health care services* provided at any nursing facility or convalescent home or *charges* billed by any place that is primarily for rest, the aged, or the *treatment* of *substance use disorders*, except as specifically stated in Section 9. G. (Covered Expenses / Behavioral Health Services).

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

29. Housekeeping, shopping, or meal preparation services.

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

31. *Health care services* for which proof of claim isn't provided to us as required by the Plan.

32. *Health care services* not for or related to an *illness* or *injury*, other than as specifically stated in the Plan.

33. Sales tax or any other tax, levy, or assessment by any federal or state agency or local political subdivision.

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

35. *Treatment* of weak, strained, flat, unstable or unbalanced feet; arch supports; heel wedges; lifts; orthopedic shoes; or the fitting of orthotics to aid walking or running; except as specifically stated Sections 9. P. (Covered Expenses / Diabetes Services) and 9. HH. (Covered Expenses / Orthotic Devices and Appliances).

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

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

38. Salivary hormone testing.

39. Prolotherapy.

40. Platelet-rich plasma.

41. Coma stimulation/recovery programs.

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

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

44. Car seats.

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

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

47. Medications for which the primary purpose is to preserve fertility.

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

49. Hypnosis.

50. Acupuncture.

51. Biofeedback, except for fecal/urinary incontinence.

52. Therapy services such as recreational therapy (other than recreational therapy included as part of a *treatment* program received during a *confinement* for *treatment* of *nervous or mental disorders* and/or *substance use disorders*), educational therapy, physical fitness, or exercise programs, except as specifically stated in Sections 9. I. (Covered Expenses / Cardiac Rehabilitation Services) and 9. SS. (Covered Expenses / Therapy Services).

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

54. Vocational or industrial rehabilitation including work hardening programs.

55. Sports hardening and rehabilitation.

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

57. General fitness programs, exercise programs, exercise equipment, health club or health spa fees, personal trainers, aerobic and strength conditioning, functional capacity exams, physical performance testing, and all material and products related to these programs.

58. *Health care services* provided in connection with a diagnosis of *obesity*, weight control, or weight reduction, regardless of whether such services are prescribed by a *health care practitioner* or associated with an *illness* or *injury*, except as indicated in Section 9. LL. (Covered Expenses / Preventive Care Services). Services excluded under this provision include, but are not limited to:

- **a.** Gastric or intestinal bypasses;
- **b.** Gastric balloons or banding;
- **c.** Stomach stapling;
- **d.** Wiring of the jaw;
- **e.** Liposuction;
- **f.** Any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you;
- **g.** Weight loss programs and nutritional counseling, unless *benefits* are provided elsewhere in the Plan;
- **h.** Physical fitness or exercise programs or equipment, unless *benefits* are provided elsewhere in the Plan; and
- **i.** Bone densitometry (DEXA, DXA) scans.

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

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

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

62. *Respite care*, except *respite care* that is part of *hospice care* as described under Section 9. Z. (Covered Expenses / Hospice Care).

63. Health care services associated with expenses for infertility or fertility treatment, including assisted reproductive technology, regardless of the reason for the treatment.

64. Direct attempts to achieve pregnancy or increase chances of achieving pregnancy by any means.

65. Evaluation of habitual abortions (three consecutive documented spontaneous abortions in the first or second trimesters) when not pregnant.

66. Any laparoscopic procedure during which an ovum is manipulated for the purpose of fertility treatment even if the laparoscopic procedure includes other purposes.

11. COORDINATION OF BENEFITS (COB)

A. Definitions

The following definitions apply to this Section 11. only:

1. Allowable Expense: a *health care service* or expense, including *deductibles* and *copayments*, that is covered at least in part by one or more *plans* covering the person for whom the claim is made. When a *plan* provides *benefits* in the form of services, the reasonable cash value of each service provided will be considered both an *allowable expense* and a *benefit* paid.

2. Claim Determination Period: a *calendar year*. However, it does not include any part of a year during which a person has no coverage under the Plan or any part of a year before the date this Section 11. or a similar provision takes effect.

3. Plan: any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

a. Individual or group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

b. Coverage under a governmental *plan* or coverage that is required or provided by law. It does not include any *plan* whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

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

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

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

B. Applicability

1. This Section 11. applies when you have health care coverage under the Plan and another *plan*.

2. If this Section 11. applies, the order of *benefit* determination rules will be looked at first. The rules determine whether the *benefits* of the Plan are determined before or after those of another *plan*. The *benefits* of the Plan:

a. Will not be reduced when, under the order of *benefit* determination rules, the Plan determines its benefits before another *plan*; but

b. May be reduced when, under the order of *benefit* determination rules, another *plan* determines its benefits first. This reduction is described in Subsection D. (Effect on the Benefits of the Plan) below.

C. Order of Benefit Determination Rules

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

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

b. Both those rules and the Plan's rules described in Paragraph 2. below require that the Plan's *benefits* be determined before those of the other *plan*.

2. The Plan determines its order of *benefits* using the first of the following rules which applies:

a. **Non-dependent/Dependent.** The benefits of the *plan* which covers the person as an employee, member or *subscriber* are determined before those of the *plan* which covers the person as a dependent of an employee, member or *subscriber*.

b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in Paragraph 2. c. below, when the Plan and another *plan* cover the same *child* as a dependent of different persons, called "parents", the benefits of the *plan* of the parent whose birthday falls earlier in the *calendar year* are determined before those of the *plan* of the parent whose birthday falls later in that *calendar year*; but if both parents have the same birthday, the benefits of the *plan* which covered the parent longer are determined before those of the *plan* which covered the other parent for a shorter period of time.

However, if the other *plan* does not have the rules described above but instead has a rule based upon the gender of the parent and if, as a result, the *plans* do not agree on the order of benefits, the rule in the other *plan* will determine the order of benefits.

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

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

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

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

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

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

d. **Active/Inactive Employee.** The benefits of a *plan* which covers a person as an employee who is neither laid-off nor retired or as that employee's dependent are determined before those of a *plan* which covers that person as a laid-off or retired employee or as that employee's dependent. If the other *plan* does not have this rule and if, as a result, the *plans* do not agree on the order of benefits, this Paragraph 2. d. is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the *plan* covering the person as a dependent of an active employee, the federal Medicare regulations will supersede this Paragraph 2. d.

e. **Continuation Coverage.** If a person has continuation coverage under federal or state law and is also covered under another *plan*, the following will determine the order of *benefits*:

1) First, the benefits of a *plan* covering the person as an employee, member or *subscriber* or as a dependent of an employee, member or *subscriber*;

2) Second, the benefits under the continuation coverage; and

3) If the other *plan* does not have the rule described in Subparagraph 1) and 2), and if, as a result, the *plans* do not agree on the order of *benefits*, this Paragraph 2. e. is ignored.

f. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of *benefits*, the benefits of the *plan* which covered an employee, member, *subscriber* or *dependent* longer are determined before those of the *plan* which covered that person for the shorter time.

g. **None of the Above.** If the preceding rules do not determine the *primary plan*, the *allowable expenses* will be shared equally between the *plans* meeting the definition of *plan* under this provision. In addition, the Plan will not pay more than it would have paid had it been the *primary plan*.

D. Effect on the Benefits of the Plan

1. **When This Subsection Applies.** This Subsection D. applies when, in accordance with Subsection C. (Order of *Benefit* Determination Rules), the Plan is a *secondary plan* as to one or more other *plans*. In that event, the *benefits* of the Plan may be reduced under this Subsection D. Such other *plan* or *plans* are referred to as "the other *plans*" below.

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

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

b. The benefits that would be payable for the *allowable expenses* under the other *plans*, in the absence of provisions with a purpose like that of this section, whether or not a claim is made. Under this provision, the *benefits* of the Plan will be reduced so that they and the benefits payable under the other *plans* do not total more than those *allowable expenses*.

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

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

A payment made under another *plan* may include an amount which should have been paid under the 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 the Plan. We will not have to pay that amount again. The term "payment made" means reasonable cash value of the *benefits* provided in the form of services.

G. Right of Recovery

1. If the amount of the payments we made is more than we should have paid, we may recover the excess from one or more of:

a. The persons we paid or for whom we paid;

b. Insurance companies; or

c. Other organizations.

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

H. Coverage with Medicare

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

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

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

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

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

Per Section 10. (General Exclusions) Paragraph 8., if you are eligible for Medicare as your *primary plan*, this Plan will not cover any expense that Medicare would cover regardless of whether you are actually enrolled in Medicare.

12. WHEN COVERAGE ENDS

A. General Rules

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

1. The date the Plan terminates.

2. The last day of the calendar month in which you die.

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

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

5. The last day of the calendar month in which the *subscriber's* employment terminates, if the termination occurs during the school year. If the *subscriber's* employment terminates at the end of the school year, coverage will continue through August 31.
6. The last day of the calendar month in which we determine the *subscriber* no longer meets the definition of *eligible employee*. However, the employee's coverage under the Plan may continue if the *subscriber* is:

   a. granted an approved leave of absence protected by the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), or any workers' compensation leave of absence. In this case, the *subscriber's* coverage will continue until the last day of the calendar month in which we determine the *subscriber* fails to return to work from that leave of absence; or

   b. granted a leave of absence under the *employer's* established leave of absence policy. In this case, the *subscriber's* coverage will continue no longer than three consecutive months unless a later date is specifically stated in the employer's leave of absence policy. Such leave of absence policy and any supporting documentation must be provided to us upon our request; or

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

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

7. The last day of the month in which we receive the *employer's* request to terminate a *covered person's* coverage, unless the *employer* specifies a later coverage termination date.
8. For a *subscriber's covered dependent*, the date the *subscriber's* coverage terminates under the Plan.
9. For a *subscriber's* spouse who is a *covered person*: the day the *subscriber's* spouse is no longer married to the *subscriber* due to divorce (unless otherwise specified in the divorce decree) or annulment.
10. For a *child* who is a *covered dependent*, the earliest of the following dates, as determined by us:

    a. The date specified in the divorce decree;

    b. The day in which the *child* reaches age 26, unless he/she is a *full-time student returning from military duty* or he/she qualifies as an *eligible dependent* due to his/her disability (see the definition of *eligible dependent* in Section 19. (Definitions));

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

11. For a child of a *covered dependent child (*i.e. the *subscriber's* grandchild*)*, the date the *subscriber's child* reaches age 18.
12. For any *covered dependent*, the day in which the individual no longer meets the definition of *eligible dependen*t.

13. For retirees:

	When does the retiree coverage end?	What happens to any remaining eligible dependents?
Teachers	The first of the month in which the retired teacher becomes Medicare eligible	If the teacher reaches age 65 first, the spouse stays on the Plan, but pays the full cost of the Plan until age 65. If the spouse reaches age 65 first, they are dropped from the Plan and the retiree reduces to single coverage. If the teacher dies, the spouse can continue on the Plan and will continue to pay the employee cost either until they reach age 65 or until the age the spouse would have turned 65.
Administrators	Coverage ends at the end of the 10-year period.	If the retired administer dies before the 10-year period, the spouse will remain eligible under the end of the 10-year period. Coverage would end at the end of that period.
Municipal	Ends on the 1st of the month in which the retiree becomes Medical eligible	COBRA is offered when the employee retires.

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

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

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

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

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

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

C. Special Rules for Disabled Children

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

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

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

D. Disenrollment from the Plan

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

1. You allow a non-*covered person* to use your identification card to obtain *health care services*; or

2. You have performed an act or practice that constitutes fraud or made an intentional material misrepresentation of material fact under the terms of the coverage.

13. CONTINUATION COVERAGE-FEDERAL LAW

This Section 13. only applies if the *employer* has 20 or more employees.

The *covered person* has the responsibility to inform the *employer* within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan in order to be eligible for COBRA continuation.

All *covered persons* under the Plan who would otherwise lose coverage as the result of a "qualifying event" have the right to elect continued health care coverage.

A qualifying event is any one of the following events which, but for continuation of coverage, would result in the loss of health insurance coverage:

A. The death of the *covered employee*;

B. The termination of the *covered employee* (other than by the employee's gross misconduct);

C. A reduction in a *covered employee*'s hours of employment;

D. The divorce or annulment of the *covered employee* from the employee's spouse;

E. The *covered employee*'s becoming entitled to Medicare coverage; or

F. The cessation of dependent child coverage under the terms of the Plan (for example, upon the employee's child attaining the limiting age of the Plan).

No employee, spouse or child will be considered a *covered person* unless, on the date before the qualifying event, that individual was covered under the Plan.

Within 14 days of the *employer* receiving notice to end coverage, the *employer* must notify the member of:

A. His/her option to continue his/her coverage;

B. The amount the *covered person* must pay monthly to continue his/her coverage under the Plan. The amount for continued coverage under the Plan will be the rate required for others in the Plan;

C. The manner in which and the place to which the *covered person* must make premium payment; and

D. The time by which the *covered person* must pay for continued coverage.

A *covered person* must elect continuation coverage during the 60-day period: (1) beginning on the date coverage would otherwise terminate due to a qualifying event or; (2) beginning on the date the *covered person* receives notice of his/her continuation rights.

If the member elects to continue coverage within the 60-day period, the continuation coverage must be effective as of the date of the qualifying event. A member who elects coverage will be charged with the cost of the coverage during the 60-day period.

The initial coverage premium must be received within 45 days of enrolling. Thereafter, premium payments are due in advance and payable no later than the last day of each month.

If a member fails to apply for coverage within the 60-day period described above, or he/she fails to send his/her first premium payment within 45 days of enrolling, he/she will forfeit his/her right to coverage under the Plan.

If a *covered employee* who elects continuation coverage wishes to change to family coverage to add his/her newborn natural child or adopted child, he/she must apply within 30 days of the birth, adoption or placement for adoption. The effective date for such family coverage will be the date of that child's birth, adoption or placement for adoption.

The duration of continuation coverage which begins on the date of the qualifying event is as follows:

A. For spouses of deceased employees, divorced spouses, and dependent children who would otherwise become ineligible for coverage under the Plan, continuation coverage will be provided for 36 months.

B. For terminated employees, employees with reduced hours, and spouses and dependent children who do not qualify for continuation coverage as stated in 1. above, continuation coverage will be provided for 18 months. If an employee or his/her spouse or dependent children who are covered under the Plan are disabled as defined by Social Security at the time of termination of employment or the reduction in hours which triggered the qualifying event or during the first 60 days of continuation coverage, coverage will be provided for an additional extension of 11 months at an increased premium, but only if the employee, spouse or dependent notifies the *employer* within 60 days of the date of the Social Security disability determination.

However, if one of the following events occurs before the expiration of the 18 or 36 months period, coverage will end at that time:

A. The termination of the Plan;

B. The failure to make timely premium payments under the Plan;

C. The *covered person* becomes covered under another group health plan as a result of employment, reemployment, or remarriage;

D. The *covered person* becomes entitled to Medicare benefits; or

E. The member becomes covered under another group health plan provided the new plan does not contain any exclusion or limitation with respect to any pre-existing condition of the member.

14. OTHER FEDERAL PROVISIONS

A. Family and Medical Leave Act

If an employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, a *covered employee*'s employer will continue coverage under the Plan in accordance with the employer'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:

1. Contribution is paid; and

2. The employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

1. The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or

2. 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 no new waiting period will apply.

B. Qualified Medical Child Support Orders Provision

A dependent child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

1. The name and last known mailing address of the member;

2. The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);

3. A reasonable description of the type of coverage to be provided to the child or the manner in which such coverage is to be determined; and

4. The period to which the order applies.

Please contact the Plan Administrator if you would like a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

C. Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers offering group health coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of the above periods. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Also under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

D. Summary of Material Reductions Rule

HIPAA requires group health plans to furnish each member with a summary of any material reductions in covered benefits no later than 60 days after the adoption of the change.

E. Additional Provisions

This group health plan also complies with the following provisions:

1. Mental Health Parity Act.

2. Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.

3. Pediatric Vaccines regulation, whereby employers will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.

4. Coverage of Dependent children in cases of adoption or placement for adoption as required by ERISA.

5. Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA).

6. Medicare Secondary Payer regulations, as amended.

7. Uniformed Services Employment and Re-employment Rights Act (USERRA).

15. GENERAL PROVISIONS

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

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

B. Your Right to Choose Medical Care

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

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

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

   a. Any *health care provider* who has diagnosed, attended, treated, advised or provided *health care services* to you;

   b. Any *hospital* or other health care facility in which you were treated or diagnosed;

   c. Any other insurance company, service, or benefit plan that possesses information that we need to determine your *benefits* under the Plan.

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

D. Assignment of Benefits

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

E. Subrogation

We have the right to subrogate against a third party or to seek reimbursement from you for the medical expenses necessarily incurred by you and related to an *illness* or *injury* caused by a third party. When you receive a *benefit* under the

Plan for an *illness* or *injury*, we are subrogated to your right to recover the reasonable value of the services provided for your *illness* or *injury* to the extent of the *benefits* we have provided under the Plan.

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

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

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

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

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

F. Limitation on Lawsuits and Legal Proceedings

By accepting coverage under the Plan, you agree that you will not bring any legal action against us regarding *benefits*, claims submitted, the payment of *benefits* or any other matter concerning your coverage until the earlier of: (1) 60 days after we have received the claim described in Section 16. (Internal Claims and Appeal Procedures); or (2) the date we deny payment of *benefits* for a claim. This provision does not apply if waiting will result in loss or *injury* to you. However, the mere fact that you must wait until the earlier of the above dates does not alone constitute loss or *injury*.

By accepting coverage under the Plan, you also agree that you will not bring any legal action against us more than three years after the claim filing deadline outlined in Section 16. (Internal Claims and Appeal Procedures).

G. Conformity with Applicable Laws and Regulations

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

H. Refund Requests

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

I. Workers' Compensation

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

1. The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the *illness* or *injury* was sustained in the course of or resulted from employment;
3. The medical or health care *benefits* are specifically excluded from the workers' compensation settlement or compromise; or
4. The workers' compensation settlement or compromise purports to be limited to lost wages or other recovery other than medical expenses.

J. Written Notice

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

K. Plan Modification and Amendment

The *employer* may modify or amend the Plan from time to time at its sole discretion, and such amendments or modifications which affect covered persons will be communicated to the *covered persons*. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications, and shall be signed by the *employer*'s designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the *employer*, or a written copy thereof shall be deposited with such master copy of the Plan. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to covered persons shall be timely made by the *employer*.

L. Conformity with Statute(s)

Any provision of the Plan which is in conflict with statutes which are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

M. Plan is Not a Contract

The Plan shall not be deemed to constitute a contract between the *employer* and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the *employer* or to interfere with the right of the *employer* to terminate the employment of any employee at any time.

N. Covered Person's Rights if Plan is Amended or Terminated

If the Plan is amended, the *covered person*'s rights are limited to Plan benefits in force at the time expenses are incurred, whether or not the *covered person* has received written notification from the Plan Administrator that the Plan has been amended.

If the Plan is terminated, the rights of a *covered person* are limited to covered expenses incurred before he/she receives notice of termination.

The Plan will assume that the *covered person* has received the written amendment or termination letter from the Plan Administrator three days after the letter is mailed to the *covered person* regarding the changes.

No person will become entitled to any vested rights under the Plan.

16. INTERNAL CLAIMS AND APPEAL PROCEDURES

A. Proof of Claim

A *covered person*, or the *physician*, *hospital* or other *health care provider* on the *covered person's* behalf, must submit written proof of his/her claim for each *health care service* provided to him/her to the *Claim Administrator* within 90 days of the date on which he/she receives that *health care service*. Written proof of his/her claim includes: (1) the completed claim forms if required by the *Claim Administrator*; (2) the actual itemized bill for each *health care service*; and (3) all other information that the *Claim Administrator* needs to determine the *employer's* liability to pay benefits under the Plan, including, but not limited to, medical records and reports.

Circumstances beyond a *covered person's* control might prevent him/her from submitting such proof to the *Claim Administrator* within this time period. If so, he/she must file written proof of his/her claim with the *Claim Administrator* as soon as possible; but it can't be later than one year and 90 days after such *health care service* was provided to him/her, unless the *covered person* is legally incapacitated as determined by a court of law during this entire period. If the *Claim Administrator* doesn't receive the written proof of claim required by the *Claim Administrator* within that one-year and 90-day period and the *covered person* is not legally incapacitated, no benefits are payable for that *health care service* under the Plan, except when required by any applicable state or federal statute.

B. Submitting a Claim

Most providers will submit claims and coordinate payment directly with the Plan on your behalf. If the provider will not coordinate payment directly with the Plan, then you will need to send the claim to the Plan at the address stated on the back of your Plan ID card within the timeframe described below.

Claims will not be deemed submitted for purposes of these claims procedures unless and until received at the correct address. However, a request for *prior authorization* for an *urgent claim* may also be filed with the Claims Administrator by telephone.

All claims submissions must be in a format acceptable to the Claims Administrator and compliant with any applicable legal requirements and shall include: (1) the completed claim forms if required by the *Claim Administrator*; (2) the actual itemized bill for each *health care service*; and (3) all other information that the *Claim Administrator* needs to determine payable benefits under the Plan, including, but not limited to, medical records and reports.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 120 days of the date on which the claim is incurred.

Circumstances beyond your control might prevent you from submitting a claim to the *Claim Administrator* within this time period. If so, you *must file the claim with the Claim Administrator as soon as possible; but not later than one year and 120 days after such health care service* was provided to you, unless you are legally incapacitated as determined by a court of law during this entire period.

Presentation of a prescription to a pharmacy does not constitute a claim. If you are required to pay the cost of a covered prescription drug, however, you may submit a claim based on that amount to the Claims Administrator.

A general request for interpretation of Plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of this Plan, should be directed to the *Plan Administrator*.

1. **Proof of payment.**

   If you receive *health care services* in a country other than the United States, you will need to pay for the *health care services* upfront and then submit the translated claim to us for reimbursement. We will reimburse you for any

covered expenses in U.S. currency. The reimbursement amount will be based on the U.S. equivalency rate that is in effect on the date you paid the claim or on the date of service if the date of payment is unknown.

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

2. Pharmacy Prescription Claims

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

C. Designating an Authorized Representative

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

If your attending health care professional requests pre-certification or prior authorization on your behalf, the attending health care professional will be treated as *your authorized representative* by the Plan for purposes of such request and the submission of your claim and associated appeals unless you specifically direct otherwise to the Plan within 10 business days from the Plan's notification that an attending *provider* was acting as your *authorized representative*. Your direction will apply to any remaining appeals.

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

If an *authorized representative* has been designated, any references to "you" or "your" in this Section. will also refer to the *authorized representative*.

If an *authorized representative*, has been designated, any references to "you" or "your" in this Section will refer to the *authorized representative*.

D. Claim Decisions

After the submission of a correctly filed claim or *prior authorization* request, the Claims Administrator will notify you within a reasonable time as follows:

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

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

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

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

If the *urgent claim* is an *incorrectly filed claim*, we will notify you of the failure to follow the proper procedures as

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

If the claim is an *incomplete claim*, we will notify you of the specific information needed as soon as possible, but no later than 24 hours after we receive the *incomplete claim*. You will then have 48 hours from the receipt of the notice to provide us with the requested information. We will notify you of our decision as soon as possible, but not later than 48 hours after the earlier of: (a) our receipt of the additional information; or (b) the end of the period of time provided to submit the additional information.

3. *Pre-Service Claim.*

We will notify you of our decision on your claim as soon as possible, but not later than 15 days after our receipt of a *pre-service claim*.

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

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

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

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

However, this period may be extended one time by an additional 15 days if we determine that an extension is necessary due to matters beyond our control. We will notify you of the extension prior to the end of the initial 30-day period, the circumstances requiring the extension, and the date by which we expect to make a decision. If the claim is an *incomplete claim*, we may extend this time by an additional 15 days, provided that we notify you that an extension is necessary and of the specific information needed prior to the end of the initial 30-day period. You will then have 45 days from the receipt of the notice to provide the requested information. Once we have received the additional information, we will make our decision within 15 days following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 90 days from the date we received the *post-service claim*.

E. Payment of Claim

If benefits are payable on *charges* for *services* covered under the Plan, we will pay such benefits directly to the *hospital*, *physician* or other *health care provider* providing such *services*, unless you advise us in writing that you have already paid the *charges* and you submit paid receipts. We will send you written notice of the benefits we paid on your behalf. If you have already paid the *charges* and are seeking reimbursement from us, payment of such benefits will be made directly to you. However, if you are seeking reimbursement for benefits provided to a child covered under a QMCSO that you already paid, payment of such benefits will be made to the child, custodial parent or, if required, state child support enforcement or Medicaid agency.

F. Notice of Adverse Benefit Determination

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

A denial notice will include information sufficient to identify the claim and will state the specific reason or reasons for the *adverse benefit determination*, the specific Plan provisions on which the determination is based, and a description of the internal and external review procedures and associated timelines, including a statement of your right to bring a civil

action under ERISA § 502(a), if applicable. The notice will include a description of any additional material or information necessary for you to perfect the claim, if applicable, and an explanation of why such material or information in necessary.

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

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

You also have the right to request, free of *charge*, the diagnosis code with its corresponding meaning and the *treatment* code with its corresponding meaning along with copies of all documents, records, and other information relevant to your claim for benefits. A request for this information, in itself, will not be considered a request for an appeal or an independent external review.

G. Appeal Procedures

1. General Appeal Information

If you disagree with the *adverse benefit determination*, then you or your *Authorized Representative* can request that the Plan review its initial determination by submitting a written appeal request to the Plan as described below. An appeal filed by a provider on your behalf is not considered an appeal under the Plan unless the provider is your *Authorized Representative*.

2. Appeal Procedure

You must file a written appeal of an *adverse benefit determination* within 180 days after receiving written notice of the *adverse benefit determination* with the Claims Administrator by mailing your appeal to the following address:

Grievance Appeal/Review Department
Attention: Appeal Coordinator
P.O. Box 1062
Minneapolis, MN 55440
1.866.631.5404

However, you may request an expedited appeal of an *adverse benefit determination* for an urgent claim orally or in writing. In such case, all necessary information, including the decision on appeal, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

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

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

For decisions regarding medical judgment, the Grievance Appeal/Review Department will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will neither be the same individual who was consulted regarding the initial *adverse benefit determination* nor a subordinate of such individual. You have the right to request, free of charge, the identity of the health care professional whose advice we obtained in connection with the *adverse benefit determination*, regardless of whether such advice was relied upon in making a decision.

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

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

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

3. Appeal Decisions

All appeals received will be reviewed promptly. We will notify you of the final decision on appeal within the following timeframes, although you may voluntarily extend these timeframes if you so choose:

Pre-Service Claims: We will notify you of our final decision as soon as possible. Within 30 calendar days after your written first appeal is received by the TPA, you will receive notice of the TPA's decision, including the specific reasons for it and references to the part of the Plan on which it is based, and the procedure for requesting a second appeal from the Plan Administrator. This time period may be extended if you agree.

Within 30 calendar days after *your* written second appeal is received by the Plan Administrator, you will receive notice of the Plan Administrator's decision, including the specific reasons for it and references to the part of the Plan on which it is based. This time period may be extended if you agree.

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

***Concurrent Care*:** We will notify you of our final decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. We shall decide the appeal of a denied request to extend any *concurrent care decision* in the appeal timeframe for a *pre-service claim*, *urgent claim*, or a *post-service claim*, as appropriate to the request.

Urgent Appeals: We will notify you of our final decision as soon as possible, but not later than 72 hours after receipt of an *expedited appeal* for an *urgent claim*. If oral notification is provided, then written notification will be mailed within the next 3 days.

4. Notice of Final Benefit Determination

A written notice of a benefit determination on appeal will be provided to you by mail within the timeframes described above.

A notice of a final *adverse benefit determination* will include information sufficient to identify the claim and will state the specific reason or reasons for the final adverse *benefit determination*, the specific Plan provisions on which the determination is based, and a description of the external review procedures and associated timelines, including a statement of your right to bring a civil action under ERISA § 502(a), if applicable.

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

If the final *adverse benefit determination* is based on the definition of *medically necessary* or

experimental/investigational/unproven, then the denial notice will provide you with either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided, free of *charge*, upon your request.

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

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

17. INDEPENDENT EXTERNAL REVIEW

A. Standard Independent External Review

You must file a written request for an independent external review within 4 months after receiving written notice of the final *adverse benefit determination* that involves medical judgment or a rescission of coverage with the Claims Administrator by mailing your request to the following address:

Aspirus Health Plan, Inc.
Attention: IRO Coordinator
P.O. Box 1062
Minneapolis, MN 55440
1.866.631.5404

If the last filing date falls on a Saturday, Sunday, or a federal holiday, then the last filing date is extended to the next day that is not a Saturday, Sunday, or a federal holiday.

Within 5 business days following receipt of a request for an external review, we will complete a preliminary review of the request to determine the following:

1. If you are, or were, covered under this Plan at the time the *health care service* was requested or provided;

2. If the *adverse benefit determination* or final *adverse benefit determination* relates to your failure to meet this Plan's eligibility requirements;

3. If you have exhausted this Plan's internal appeals procedures, when required; and

4. If you have provided all the information and forms required to process an independent review.

Within 1 business day after completion of the preliminary review, we will provide written notification to you of the following:

1. If the request is complete, but not eligible for an independent external review, then the notice will include the reasons for its ineligibility and contact information for the Department of Labor, including this toll-free number: 1-866-444- 3273 and the following email address information: www.askebsa.dol.gov.

2. If the request is not complete, then the notice will describe the information or materials needed to make it complete and will allow you to perfect the request for independent external review within the initial 4-month filing period or the 48-hour period following receipt of the notification, whichever is later.

We will assign an independent review organization to conduct the independent external review. We will attempt to prevent bias by contracting with at least 3 independent review organizations for assignments and will rotate claims assignments among them, or incorporate some other independent method for selection, such as random selection.

The independent review organization will timely provide you with written notification of the request's eligibility and acceptance of the request for external review. This written notification will inform you that you may submit, in writing, additional information to the independent review organization for its consideration when conducting the independent

external review within 10 business days following the date you receive this notice.

We must provide the independent review organization the documents and any information considered in making the *adverse benefit determination* or final *adverse benefit determination* within 5 business days after assigning the independent review organization. Failure to timely provide this information will not delay the conduct of the independent external review as the assigned independent review organization may terminate the independent external review and make a decision to reverse the *adverse benefit determination* or *final adverse benefit determination* if we fail to timely provide this information. The independent review organization will notify you and the Plan within one business day of making the decision.

If the independent review organization receives any information from you, then it will forward it to the Plan within one business day. After receiving this information, we may reconsider the *adverse benefit determination* or the final *adverse benefit determination*. If the initial benefit determination is changed, then we will notify you and the independent review organization, in writing, within one business day. The assigned independent review organization will then terminate the independent external review.

The independent review organization will review all information and documents timely received. In reaching a decision, the independent review organization will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals procedures.

The independent review organization will provide written notice of its decision to you and to the Plan within 45 days after receiving the request for independent external review. If the independent review organization reverses the *adverse benefit determination* or final *adverse benefit determination*, then the Plan must immediately provide coverage or payment for the claim in question.

B. Expedited Independent External Review

We must allow you to make a request for an expedited independent external review at the time you receive:

1. An *adverse benefit determination* involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

2. A final *adverse benefit determination* involving a medical condition where the timeframe for completion of a standard independent external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

3. A final *adverse benefit determination* involving a medical condition where the final *adverse benefit determination* concerns an admission, availability of care, continued stay, or *health care service* for which you received emergency care, but have not been discharged from the facility.

A written request for an expedited independent external review must be sent to:

Aspirus Health Plan, Inc.
Attention: IRO Coordinator
P.O. Box 1062
Minneapolis, MN 55440
1.866.631.5404

We will determine whether the request meets the reviewability requirements for a standard independent external review immediately upon receiving a request for an expedited independent external review. We will immediately send a notice of its eligibility determination regarding the independent external review request that meets the requirements under the standard independent external review process set forth in subsection A. above.

If we determine that the request is eligible for independent external review, we will assign an independent review organization as set forth in subsection A. above. We will provide all necessary documents and information considered when making the *adverse benefit determination* or final *adverse benefit determination* to the assigned independent review organization electronically, by telephone/facsimile, or any other expeditious method.

The assigned independent review organization is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals procedures.

The independent review organization will provide notice of its decision as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the independent review organization receives the request for an expedited independent external review. If the notice is not in writing, then the independent review organization will send written confirmation of its decision within 48 hours to both you and the Plan.

If the independent review organization reverses the *adverse benefit determination* or final *adverse benefit determination*, then the Plan must immediately provide coverage or payment for the claim in question.

18. HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

The Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications have or will become effective as required by applicable provisions of the Privacy and Security Regulations.

First, under HIPAA Privacy Regulations, the Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. Subsection "Use and Disclosure of Protected Health Information Under HIPAA" of this section specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the uses and disclosures that the Plan Sponsor may make of your PHI.

The Plan agrees that it will only disclose your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in subsection "Use and Disclosure of Protected Health Information Under HIPAA" of this section have been adopted and the Plan Sponsor agrees to abide by these terms.

The HIPAA Privacy Regulation provision of the Plan took effect April 14, 2004.

Second, under HIPAA Security Regulations, the Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan.

A. Definitions

The following definitions apply to this section:

1. **Administrative simplification:** the section of the law that addresses electronic transactions, privacy and security. The goals are to:
   a. Improve efficiency and effectiveness of the health care system;
   b. Standardize electronic data interchange of certain administrative transactions;
   c. Safeguard security and privacy of protected health information;
   d. Improve efficiency to compile/analyze data, audit, and detect fraud; and
   e. Improve the Medicare and Medicaid programs.

2. **Business associate (BA) in relationship to a covered entity (CE):** a BA is a person to whom the CE discloses protected health information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, third party administrators, health care clearinghouses, data processing firms, billing firms and other covered entities. This excludes persons who are within the CE's workforce.

3. **Covered entity (CE):** one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

4. **Designated record set:** a set of records maintained by or for a covered entity that includes a covered persons' PHI. This includes medical records, billing records, enrollment, payment, claims adjudication and case management record systems maintained by or for the Plan. This also includes records used to make decisions about covered persons. This record set must be maintained for a minimum of six years.

5. **Disclose or disclosure:** the release or divulgence of information by an entity to persons or organizations outside that entity.

6. **Electronic protected health information (electronic PHI):** individually identifiable health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of protected health information.

7. **Health care operations:** general administrative and business functions necessary for the CE to remain a viable business. These activities include:

    a. Conducting quality assessment and improvement activities;
    b. Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
    c. Evaluating health care professional and health plan performance;
    d. Training future health care professionals;
    e. Insurance activities relating to the renewal of a contract for insurance;
    f. Conducting or arranging for medical review and auditing services;
    g. Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
    h. Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
    i. Contacting of health care providers and patients with information about treatment alternatives and related functions that do not entail direct patient care; and
    j. Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

8. **Health Information:** any information, oral or recorded in any medium, that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present or future physical or mental health or condition of a *covered person*; the provision of health care to a *covered person*; or the past, present or future payment for the provision of the health care to a *covered person*.

9. **Individually identifiable health information:** information that is a subset of health information, including demographic information collected from a *covered person*, and that:

    a. Is created by or received from a covered entity;
    b. Relates to the past, present or future physical or mental health or condition of a covered person, the provision of health care or the past, present or future payment for the provision of health care; and
    c. Identifies the covered person or with respect to which there is reasonable basis to believe the information can be used to identify the covered person.

10. **Payment:** the activities of the health plan or a business associate, including the actual payment under the Plan or contract; and a health care provider or its business associate that obtains reimbursement for the provision of health care.

11. **Plan Sponsor:** your *employer*.

12. **Plan Administration Functions:** administration functions of payment or health care operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims process, auditing and monitoring and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

13. **Privacy Official:** the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a covered person's privacy.

14. **Protected Health Information:** individually identifiable health information that is or has been electronically maintained or electronically transmitted by a covered entity, as well as such information when it takes any other form or medium. Protected health information excludes individually identifiable health information in:(1) education records covered by the Family Education Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (2) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (3) employment records held by a covered entity in its role as *employer*.

15. **Summary Health Information:** information, that may be individually identifiable health information, and: (1) that summarizes the claims history, claims expenses, or type of claims experienced by *covered person*s for whom the *employer* has provided health benefits under the Plan; and (2) from which the identifiers of the *covered person*s or of relatives, *employer*s, or household members of the *covered person* specified in 45 C.F.R. section 154.504(a), are removed.

16. **Treatment:** the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

17. **Use:** means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

B. Disclosure of Protected Health Information

The Plan will use your protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose your PHI for purposes related to health care treatment, payment for health care and health care operations. Additionally, the Plan will use and disclose your PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share your PHI with the Plan Sponsor, and limits the uses and disclosures that the Plan Sponsor may make of your PHI.

The Plan shall disclose your PHI to the Plan Sponsor, only to the extent necessary for the purposes of the administrative functions of treatment, payment for health care or health care operations.

The Plan Sponsor shall use and/or disclose your PHI only to the extent necessary for the administrative functions of treatment, payment for health care or health care operations which it performs on behalf of the Plan.

The Plan agrees that it will only disclose your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

This section reflects the modification of the Plan as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to allow the disclosure of protected health information ("PHI") to the Employer, for the purposes specified below.

1. **Use and Disclosure of PHI by the Employer.**

   The Employer shall use and/or disclose PHI only to the extent necessary to perform Plan administration functions, which it performs on behalf of the Plan.

2. **Disclosure of PHI to the Employer.**
   The Plan shall disclose PHI to the *employer* only to the extent necessary to perform Plan administration functions.

   The Plan agrees that it will only disclose PHI to the *employer* when this section has been adopted and the *employer* agrees to abide by the provisions of this section as evidenced by certification attached to the Plan. The *employer* is subject to the following:

   a) Prohibition on Unauthorized Use or Disclosure of PHI. The *employer* will not use or disclose any PHI received from the Plan, except as permitted in this section or required by law.

   b) Subcontractors and Agents. The e*mployer* will require each of its subcontractors or agents to whom the *employer* may provide PHI to agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the *employer*.

   c) Permitted Purposes. The *employer* will not use or disclose PHI for employment-related actions and decisions or in connection with any other of the *employer*'s benefits or employee benefit plans.

   d) Reporting. The *employer* will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for which it becomes aware. This includes any security incidents with respect to electronic PHI.

   e) Access to PHI by *Covered Persons* . The *employer* will make PHI available to the Plan to permit *covered persons* to inspect and copy their PHI contained in the designated record set, in accordance with 45 C.F.R. section 164.524.

   f) Correction of PHI. The *employer* will make a *covered person's* PHI available to the Plan to permit *covered persons* to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and the *employer* will incorporate amendments provided by the Plan, in accordance with 45 C.F.R. section 164.526.

   g) Accounting of PHI. The *employer* will make a *covered person's* PHI available to permit the Plan to provide an accounting of disclosures, in accordance with 45 C.F.R. section 164.528.

   h) Disclosure to Government Agencies. The e*mployer* will make its internal practices, books and records relating to the use and disclosure of PHI available to the Department of Health and Human Services for purposes for purposes of determining the Plan's compliance with the HIPAA Privacy Rule.

   i) Return or Destruction of Health Information. When the PHI is no longer needed for the purpose for which disclosure was made, the *employer* must, if feasible, return to the Plan or destroy all PHI that the *employer* received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the *employer* agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

j) Electronic PHI. The *employer* agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan, and it will ensure that any agent, including a subcontractor, to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The e*mployer* will report to the Plan any security incident of which it becomes aware.

k) Disclosure Log. The Plan Sponsor will keep a disclosure log for certain types of disclosures set forth in the HIPAA Regulations. You have a right to see the disclosure log. The Plan Sponsor does not have to maintain a log if disclosures are for certain Plan-related purposes such as payment of benefits or health care operations.

l) Minimum Necessary PHI. The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of your PHI to carry out functions for which the information is requested.

3. Adequate Separation.
The *employer* represents that adequate separation exists between the Plan and the *employer* so that PHI will be used only for Plan administration. The following employees or classes of employees or other persons under the control of the *employer* have access to *covered persons'* PHI to perform Plan administration functions: the *employer's* Human Resource Department or any employee with oversight responsibility for claims administration.

The *employer* will ensure that the provisions of this paragraph 3. are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

4. Adequate Separation Certification.
The Plan requires the e*mployer* to certify that the employees identified above are the only employees that will access and use *covered persons'* PHI. The *employer* must further certify that such employees will only access and use PHI to perform Plan administration functions.

5. Enrollment/Disenrollment Information.
Notwithstanding the above, the Plan, or a health insurance issuer, HMO or TPA with respect to the Plan, may disclose to the *employer* information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

6. Summary Health Information.
Notwithstanding the above, the Plan, or a health insurance issuer, HMO or TPA with respect to the Plan may disclose summary health information to the *employer*, provided the *employer* requests the summary health information for the purpose of: (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

7. Reports of Non-Compliance.
Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Official or other Plan representative to help resolve any potential issues of non-compliance.

The following employees, classes of employees or other workforce members under the control of the Plan Sponsor may be given access to your PHI for Plan administrative functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section: the Plan Sponsor's Human Resource Department or any employee with oversight responsibility for claims administration.

This list includes every employee, class of employees or other workforce members under the control of the Plan Sponsor who may receive your PHI. If any of these employees or workforce members use or disclose your PHI in violation of the terms set forth in this section, the employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan

Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to you.

19. DEFINITIONS

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

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

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

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

An *adverse benefit determination* includes any rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, regardless of whether or not, in connection with the rescission, there is an adverse effect on any particular *benefit* at that time.

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

Appeal: any dissatisfaction with us or our administration of your health *benefit plan* that you express to us in writing.

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

Behavioral Health Services: *health care services* for the *treatment* of *substance use disorders* and *nervous or mental disorders*.

Benefit: your right to payment for covered *health care services* that are available under the Plan. Your right to *benefits* is subject to the terms, conditions, limitations and exclusions of the Plan, including this Certificate, the Schedule of Benefits and any attached endorsements.

Birthing Center: a facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant *covered person* under the direction and supervision of one or more h*ealth care practitioners* specializing in obstetrics or gynecology. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

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

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

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

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

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

(3) Fall under a covered *benefit* category and not excluded by law, regulation or current Medicare coverage guidelines;

(4) *Medically necessary* for the *covered person*, and the amount, duration and frequency of use or application of the service is medically appropriate; and

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

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

Child/Children: any of the following:

1. A biological *child* of a *subscriber*.

2. A step-child of a *subscriber*.

3. A legally adopted child or a child placed for adoption with the *subscriber*.

4. A *child* under the *subscriber's* (or his/her spouse's) legal guardianship as ordered by a court. To be initially eligible for coverage, the *child* must be under the age of 18 and you must have sole and permanent guardianship of both the *child* and his/her estate.

5. A *child* who is considered an alternate recipient under a qualified medical child support order. See Section 6. G. (Eligibility, Enrollment, and Effective Date / Special Enrollment Periods / Child Support Order) for additional information about child support orders.

6. The *child* of a *subscriber's domestic partner* provided that:

a. the *domestic partner* is enrolled as a *covered person* under the Plan; and

b. the *domestic partner* is the biological parent or has a court-appointed legal relationship with the *child* (i.e. through adoption).

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

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

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

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

Correctly Filed Claim: a claim that includes: (1) the completed claim forms that we require; (2) the actual itemized bill for each health care service; and (3) all other information that we need to determine our liability to pay benefits under the Plan, including but not limited to, medical records and reports.

Cosmetic Treatment: any *health care service* used solely to: (1) change or improve your physical appearance or self-esteem; or (2) treatment of a condition that causes no *functional impairment* or threat to your health.

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

Covered Dependent: an *eligible dependent* who has properly enrolled and been approved by us for coverage under the Plan.

Covered Employee: a *subscriber***.**

Covered Expenses: any *charge*, or any portion thereof, that is eligible for full or partial payment under the Plan.

Covered Person: a *subscriber* and/or his/her *covered dependent(s)*.

Custodial Care: services that are any of the following:

1. Non-health-related services, such as assistance in *activities of daily living*.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function unless eligible for *habilitative services benefits* (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. 24-hour supervision for potentially unsafe behavior.
4. Supervision of medication which usually can be self-administered.
5. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

1. You are under the care of a *health care practitioner*;
2. The *health care practitioner* prescribes *health care services* to support and maintain your physical and/or mental condition;
3. Services are being provided by a nurse; or
4. Such care involves the use of technical medical skills if such skills can be easily taught to a layperson.

Deductible: the specified amount you are required to pay for *covered expenses* in a *calendar year* before *benefits* are payable under the Plan.

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

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

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

Eligible Dependent: an individual who falls into one or more of the five categories below and who is not on active military duty for longer than 30 days:

1. A *subscriber's* legal spouse.
2. A *subscriber's child*, under the age of 26.
3. A *full-time student returning from military duty*.
4. A *subscriber's child* over age 26 if all of the following criteria are met:
   a. the *child* is incapable of self-sustaining employment because of intellectual disability or physical handicap;
   b. the *child* is chiefly dependent upon the *subscriber* for support and maintenance;
   c. the *child's* incapacity existed before he/she reached age 26; and
   d. the *subscriber's family coverage* remains in force under the Plan.
5. A natural *child* of a *subscriber's child* if the *subscriber's child* is under 18 years old.

Eligible Employee: a person who is either (1) employed by the *employer* on a permanent, full-time basis (or part-time basis) for a minimum number of hours listed below; or (2) identified by the *employer* as a person that must be covered pursuant to the Patient Protection and Affordable Care Act.

Administrators:	20 or more hours per week
Teachers:	16 or more hours per week
Food Service:	30 or more hours per week
Clerical:	1,000 or more hours per year
Maintenance & Custodial:	1,040 or more hours per year
Municipal:	600 or more hours per year

Employer: Wausau School District

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

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

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

1. It is not currently recognized as accepted medical practice;
2. It was not recognized as accepted medical practice at the time the *charges* were incurred;
3. It has not been approved by the United States Food and Drug Administration (FDA) upon completion of Phase III clinical investigation;
4. It is being used in a way that is not approved by the FDA or listed in the FDA-approved labeling (*i.e.* off-label use), except for off-label uses that are accepted medical practice);
5. It has not successfully completed all phases of clinical trials, unless required by law;
6. It is based upon or similar to a treatment protocol used in on-going clinical trials;
7. Prevailing peer-reviewed medical literature in the United States has failed to demonstrate that it is safe and effective for your condition;
8. There is not enough scientific evidence to demonstrate or make a convincing argument that (a) it can measure or alter the sought-after changes to your *illness* or *injury* or (b) such measurement or alteration will affect your health

outcome; or support conclusions concerning the effect of the drug, device, procedure, service or *treatment* on health outcomes; or

9. It is associated with a Category III CPT code developed by the American Medical Association.

The above list is not all-inclusive.

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

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

Family Coverage: coverage that applies to a *subscriber* and his/her *covered dependents*. When referred to in this Certificate, *family coverage* also includes *limited family coverage*.

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

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

1. The *child* was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the *child* was attending, on a full-time basis, an institution of higher education;

2. The *child* was under the age of 27 when called to federal active duty; and

3. Within 12 months after returning from federal active duty, the *child* returned to an institution of higher education on a full-time basis, regardless of age.

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

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

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

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

Geographical Service Area: the region in which Aspirus Health Plan, Inc. operates and your *plan* is available, as determined by us. Please see www.aspirushealthplan.com for more information.

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

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

Health Care Services: diagnosis, *treatment*, *hospital* services, *surgical services* as defined in Section 9. PP. (Covered Expenses / Surgical Services), maternity services, *medical services*, procedures, drugs, medicines, devices, *supplies*, or any other service directly provided to you by a *health care provider*

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

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

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

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

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

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

Limited Family Coverage: coverage that applies to: (1) a *subscriber* and his/her eligible spouse who is a *covered dependent*; or (2) a *subscriber* and his/her *children* who are *covered dependents*.

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

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

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

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

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

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

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

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

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

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

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

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

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

Office Visit: either of the following:

1. For *health care services* other than *behavioral health services*, a meeting between you and a *health care practitioner* that: (a) occurs at the *health care practitioner's* office, a medical clinic, *convenient care clinic*, an ambulatory surgical center, a free-standing *urgent care* center, *skilled nursing facility*, the outpatient department of a *hospital*, other than an emergency room, or in your home; and (b) includes you receiving medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology or as determined by us) or manipulations by a *health care practitioner*, other than services related to physical therapy.
2. For *behavioral health services*, a meeting between you and a *health care practitioner* licensed to provide nonresidential services for the *treatment* of *nervous or mental disorders* and/or *substance use disorders* that: (a) occurs in the *health care practitioner's* office, a medical clinic, a free-standing *urgent care* center, *skilled nursing facility*, outpatient *treatment* facility, the outpatient department of a *hospital* other than an emergency room, or in your home; and (b) involves you receiving psychotherapy, psychiatric diagnostic interviews, medication management, electro-shock therapy, behavioral counseling, or neuropsychological testing.

Out-of-Network Usual and Customary Amount: the *benefit* limit established by us for a covered *health care service*

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

Out-of-Pocket Limit: the maximum amount that you are required to pay each *calendar year* for *covered expenses*. This limit is shown in the Schedule of Benefits. Any of the following costs will count towards your *out-of-pocket limit*: (1) *deductible*; (2) *copayments*; and (3) *coinsurance* amounts you pay for *covered expenses* associated with *health care services*. In determining whether you've reached your *out-of-pocket limit*, the following amounts will not count: (1) amounts you pay for non-covered *health care services*; and (2) amounts you pay that exceed the *usual and customary amount*.

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

Physical Illness: a disturbance in a function, structure or system of the human body that causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of health status or of the function, structure or system of the human body. *Physical illness* includes pregnancy and complications of pregnancy. *Physical illness* does not include *substance use disorders* or *nervous or mental disorders*.

Physician: a person who:

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

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

1. A county department, or a child welfare agency places a *child* in a *subscriber's* home for adoption and enters into an agreement or (2) with the *subscriber*;
2. A county department or a child welfare agency places, or a court orders, a *child* placed in a *subscriber's* home for adoption;
3. A sending agency places a *child* in a *subscriber's* home for adoption, or a public child placing agency or a private child placing agency, of a sending state, places a *child* in the *subscriber's* home as a preliminary step to a possible adoption, and the *subscriber* takes physical custody of the *child* at any location within the United States;
4. The person bringing the *child* into this state has complied with the law, and the *subscriber* takes physical custody of the *child* at any location within the United States; or
5. A court of a foreign jurisdiction appoints a *subscriber* as guardian of a *child* who is a citizen of that jurisdiction, and the *child* arrives in the *subscriber's* home for the purpose of adoption by the *subscriber*.

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

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

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

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

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

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

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

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

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

Skilled Nursing Care: *health care services* that: (1) are furnished pursuant to a *health care practitioner's* orders; (2) require the skills of professional personnel such as a registered nurse or a licensed practical nurse; and (3) are provided either directly by or under the direct supervision of such professional personnel. Patients receiving *skilled nursing care* are usually quite ill and often have been recently *confined* in a *hospital*. In the majority of cases, *skilled nursing care* is only necessary for a limited time period. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, *children*, or other family or relatives. The following examples are generally considered care that can be provided by "nonskilled" persons, and therefore do not qualify as *skilled nursing care*: range of motion exercises, strengthening exercises, simple wound care, ostomy care, tube and gastrostomy feedings, administration of basic medications, maintenance of urinary catheters, assistance with performing *activities of daily living*, and supervision for potentially unsafe behavior.

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

1. Is operating pursuant to state and federal law;
2. Is under the full-time supervision of a *health care practitioner* or registered nurse;
3. Provides services seven days a week, 24 hours a day, including *skilled nursing care* and therapies for the recovery of health or physical strength;
4. Is not a place primarily for custodial or *maintenance care*;
5. Requires compensation from its patients;
6. Admits patients only upon a *health care practitioner's* orders;
7. Has an agreement to have a *health care practitioner's* services available when needed;
8. Maintains adequate records for all patients; and
9. Has a written transfer agreement with at least one *hospital*.

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

Subscriber: an *eligible employee* who has properly enrolled and been approved by us for coverage under the Plan. Also includes retirees that satisfy the requirements in Section. 6. C. (Eligibility, Enrollment, and Effective Date/ Retiree Eligibility.)

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

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

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

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

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

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

Urgent Claim: any *pre-service claim* for medical care or *treatment* with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or in the opinion of a *health care practitioner* with actual knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or *treatment* that is the subject of the claim.

Usual and Customary Amount: the maximum amount of reimbursement allowed for a covered *health care service*. For a covered *health care service* provided by a *participating provider*, the *usual and customary amount i*s the rate negotiated between us and the *participating provider*. For a covered *health care service* provided by a *non-participating provider*, the *usual and customary amount* is the *out-of-network usual and customary amount*.

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

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

Waiting Period: a period of time that must pass before an individual is eligible to be covered for *benefits* under the provisions of the Plan.