

AMBETTER FROM MHS HEALTH WISCONSIN
EVIDENCE OF COVERAGE
HEALTH MAINTENANCE ORGANIZATION
Home Office: 10700 Research Drive. Milwaukee, WI 53226

Individual Member Contract

In this *contract*, "*you*", "*your*", "*yours*" or "*member*" will refer to the subscriber and/or any Dependents named on the Schedule of Benefits and "*we*," "*our*," or "*us*" will refer to MHS Health Wisconsin.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is made a part of the *contract*. We will provide benefits to *you*, the *member*, for covered *loss* due to *illness* or *bodily injury* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *contract* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *contract effective date* if: (1) *we* refuse to renew all contracts issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) *we* withdraw from the service area or reach demonstrated capacity in a service area in whole or in part; (3) there is fraud or a material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

From time to time, *we* will change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of *members*, type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums after filing and approval by the state.

At least 31 day notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. We will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force.

As a cost containment feature, this *contract* contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

WARNING: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

TEN DAY RIGHT TO RETURN CONTRACT

Please read your *contract* carefully. If you are not satisfied, return this *contract* to us or to our agent within 10 days after you receive it. All premiums paid will be refunded, less claims paid, and the *contract* will be considered null and void from the *effective date*.

MHS Health Wisconsin

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A handwritten signature in black ink, appearing to read "Sherry B. Husa". The signature is fluid and cursive, with the first name "Sherry" being more prominent.

Sherry Husa
CEO and Plan President

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INTRODUCTION

Welcome to Ambetter from Manage Health Services! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

- how to access medical care.
- what health services are covered by *us*.
- what portion of the health care costs *you* will be required to pay.

This *contract*, the Schedule of Benefits, the application as submitted to the exchange, and any amendments or riders attached shall constitute the entire contract under which *covered services* and supplies are provided or paid for by *us*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

How To Contact Us

Ambetter from MHS Health Wisconsin
10700 Research Dr.
Milwaukee, WI 53226

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST

Member Services **1-855-745-5506**

TDD/TTY line **1-800-947-3529**

Fax **1-844-784-2438**

Emergency **911**

NurseWise **1-855-745-5506 (24 hour nurse advice line)**

Interpreter Services

Ambetter from MHS Health Wisconsin has a free service to help our *members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at **1-855-745-5506** (TDD/TTY **1-800-947-3529**).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between you, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice complaints or *appeals* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician(s)* of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such notices shall include the following:
 - a. Any changes in clinical review criteria
 - b. A statement of the effect of such changes on the personal liability of the *member* for the cost of

any such changes.

14. A current list of *network providers*. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
16. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
17. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
18. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care physician's* instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. Your *primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
19. Select your *primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
20. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
21. An interpreter when *you* do not speak or understand the language of the area.
22. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
23. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
24. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help your *primary care physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
 - a. Living Will
 - b. Health Care Power of Attorney
 - c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show your I.D. card and keep scheduled appointments with your *physician*, and call the *physician's* office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of your assigned *primary care physician*. *You* should establish a relationship with your *physician*. *You* may change your *primary care physician* verbally or in writing by contacting our **Member Services Department**.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.

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8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
15. Pay *your* monthly premium, all *deductible amounts*, *copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* member service department know if *you* have any changes to *your* name, address, or family members covered under this *contract*.

Your Provider Directory

A listing of *network providers* is available online at <http://ambetter.mhswi.com/>. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. You may find any of our *network providers* by completing the “Find a Doctor” function on *our* website and selecting the Ambetter from MHS Health Wisconsin network. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at **1-855-745-5506**. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member*. *We* can also help *you* pick a *primary care physician* (PCP). *We* can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician's* office if you want to make an appointment. If *you* need help, call Member Services at **1-855-745-5506**. *We* will help *you* make the appointment.

Your Member ID Card

When *you* enroll, *we* will mail a member ID card to *you* within 5 business days of *our* receipt of *your* enrollment materials. This card is proof that *you* are enrolled in a MHS Health Wisconsin **Plan**. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*. The ID card will show *your* name, *member ID#*, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at **1-855-745-5506**, twenty-four hours per day, seven days a week. *We* will send *you* another card.

Our Website

Our website helps *you* get the answers to many of *your* frequently asked questions. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at <http://ambetter.mhswi.com/>. It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. Our programs and services.
6. The quarterly newsletter, Healthy Moves.
7. Current events and news.

You may also access the Federal Government's website at www.healthcare.gov/center/regulations/prevention.html to obtain current information.

Quality Improvement

We are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee on Quality Assurance (NCQA) standards. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the healthcare *you* are receiving.
6. A Quality Improvement Committee which includes *network providers* to help us develop and monitor our program activities.
7. Investigating any *member* concerns regarding care received.

For example, if *you* have a concern about the care *you* received from your *network physician* or service provided by *us*, please contact the Member Services Department.

We believe that getting *member* input can help make the content and quality of *our* programs better. *We* conduct a *member* survey each year that asks questions about *your* experience with the healthcare and services *you* are receiving.

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week, while the covered person is confined as an inpatient in a hospital, rehabilitation facility, or *extended care facility*.

Advance the premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Affordable Care Act "ACA" means the comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law. This is often times referred to as Health Care Reform.

Allogeneic bone marrow transplant or **BMT** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

Autism Spectrum Disorder means any of the following:

- Autism disorder.
- Asperger's syndrome.
- Pervasive development disorder not otherwise specified.

Autologous bone marrow transplant or **ABMT** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

Bereavement counseling means counseling of members of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *listed transplants* or other services such as cancer, bariatric or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence*.

Chiropractic Care involves neuromuscular treatment in the form of manipulation and adjustment of the tissues of the body, particularly of the spinal column and may include physical medicine modalities or use of *durable medical equipment*.

Complaint means any expression of dissatisfaction expressed to the insurer by the member, or a member's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency caesarean section* or a *non-elective caesarean section*.

Continuous loss means that *covered service expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered service expense* for the *illness* or *injury* must have been incurred before coverage of the *member* ceased under this *contract*. Whether or not *covered service expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

Contract when *italicized*, means this *contract* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Copayment amount means the amount of *covered services* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* application of any *cost sharing percentage*.

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

Cost sharing percentage means the percentage of *covered services* that is payable by *us*.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Health Insurance Marketplace.

Covered service or covered service expenses means services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician*. To be a *covered service* the service, supply or treatment must be

1. Provided or incurred while the *member's* coverage is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

Custodial Care is treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Deductible amount means the amount of *covered expenses*, shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount*. For family coverage, the family deductible amount can be met with the combination of any one or more covered persons' eligible expenses.

The *deductible amount* does not include any *copayment amounts*.

Dental services means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental services* regardless of the reason for the services.

Dependent member means *your spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date a *member* becomes covered under this *contract* for *covered services*.

Eligible cancer clinical trial means a cancer clinical trial that meets all of the following criteria:

- (a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- (b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- (c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- (d) The trial does one of the following:
 - (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
 - (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
 - (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
 - (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.
- (e) The trial is approved by one of the following entities:
 - (i) The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;
 - (ii) The United States food and drug administration;
 - (iii) The United States department of defense;
 - (iv) The United States department of veterans' affairs.

Eligible child means the child of a covered person, if that child is less than 26 years of age or age 28 under certain circumstances as shown in the Ongoing Eligibility section. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A stepchild;

4. A child placed with *you* for adoption; or
5. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify the Exchange if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* provide or pay for a child at a time when the child did not qualify as an *eligible child*.

Eligible service expense means a *covered service* as determined below.

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.
2. For *non-network providers*:
 - a. When a *covered service* is received from a *non-network provider* as a result of an *emergency*; or
 - b. as otherwise approved by *us*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts

When a *covered service expense* is received from a *non-network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the greater of the amount that would be paid under Medicare or the amount negotiated with in-network providers for the *covered service*. If there is more than one amount negotiated with in-network providers for the *covered service*, the amount is the median of these amounts.

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, Emergency services, Hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, Prescription Drugs, Rehabilitative and habilitative services and devices, laboratory services, Preventive and wellness services and Chronic disease management and pediatric services, including oral and vision care. Essential Health Benefits provided within this Contract are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

Emergency means a medical condition manifesting itself by such acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the *member* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

If *you* are experiencing an emergency, call 9-1-1 or go to the nearest *hospital*. If those services provided are utilized at a *non-network hospital*, and a *member* presents self with an emergency medical condition under one of the following circumstances emergency care will be covered:

- a) Due to circumstances beyond the *member's* control, the *member* was unable to utilize a *network hospital's* emergency department without serious threat to life or health.
- b) A prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a *network hospital's* emergency department could result in one or more of the adverse health consequence.
- c) A person authorized by *us* refers the *member* to an emergency department and does not specify a *network hospital's* emergency department.
- d) An ambulance takes the *member* to a *non-network hospital* other than at the direction of the *member*
- e) The *member* is unconscious.
- f) A natural disaster precluded the use of a *network hospital's* emergency department.

- g) The status of a *hospital* changed from *network* to *non-network hospital* with respect to emergency services during a contract year and no good faith effort was made by *us* to inform *members* of this change.

Experimental or investigational treatment means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service*.
3. Subject to *USFDA* approval, and:
 - a. It does not have *USFDA* approval;
 - b. It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
 - c. It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:
 - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
 - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
 - iii. Not an *unproven service*; or
 - d. It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *USFDA* clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise Covered Services under this Contract.

Extended care facility means an institution, or a distinct part of an institution, that:

1. Is licensed as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a *physician*; and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance abuse*, *custodial care*, nursing care, or for care of *mental disorders* or the mentally incompetent.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a

covered service under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

Home health aide services means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *member*.

Home health care means care or treatment of an *illness* or *injury* at the *member's* home that is:

1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

Home health care agency means a public or private agency, or one of its subdivisions, that:

1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician*, in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care*.

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

Hospice means an institution that:

1. Provides a *hospice care program*;
2. Is separated from or operated as a separate unit of a *hospital*, *hospital-related* institution, *home health care agency*, mental health facility, *extended care facility*, or any other licensed health care institution;
3. Provides care for the *terminally ill*; and
4. Is licensed by the state in which it operates.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill member* and those of his or her *immediate family*.

Hospital means an institution that:

1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility*; a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility*, or *residential treatment facility*,

halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

Illness means a sickness, disease, or disorder of a *member*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *member*, or any person residing with a *member*.

Injury means accidental bodily damage sustained by a *member* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a Cardiac Care Unit, or other unit or area of a *hospital* that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Intensive day rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week.

Intensive-level services means evidence-based behavioral therapies that is designed to help an individual with autism spectrum disorder overcome the cognitive, social and behavioral deficits associated with that disorder.

Licensed Mental Health Professional means a professional that holds a clinical license in a behavioral health discipline; and possesses the training or experience to complete the required evaluation and treatment of behavioral health disorders.

Listed transplant means one of the following procedures and no others:

1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions:
 - a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
 - b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
 - c. *BMT* for Severe Aplastic Anemia.
 - d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
 - e. *BMT* for Chronic Myelogenous Leukemia.
 - f. *ABMT* for Testicular Cancer.
 - g. *BMT* for Severe Combined Immunodeficiency.
 - h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
 - i. *BMT* for Myelodysplastic Syndrome.
 - j. *BMT* for Wiskott-Aldrich Syndrome.
 - k. *BMT* for Thalassemia Major.
 - l. *BMT* or *ABMT* for Multiple Myeloma.
 - m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.

- n. *BMT* for Fanconi's anemia.
- o. *BMT* for malignant histiocytic disorders.
- p. *BMT* for juvenile.

Loss means an event for which benefits are payable under this *contract*. A *loss* must occur while the *member* is covered under this *contract*.

Loss of Minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), however this will not apply to a dependent living outside the service area if a court order requires the member to cover the dependent;
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
6. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.
7. In the case of an employee or dependent that has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount is the sum of the deductible amount, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance percentage of covered expenses*, as shown in the Schedule of Benefits. After the *maximum out-of-pocket amount* is met for an individual, MHS Health Wisconsin Plan pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of-pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum per calendar year as shown in the Schedule of Benefits.

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Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a covered person's medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy*: acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *member's illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

Charges incurred for treatment not *medically necessary* are not *eligible service expenses*.

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury or illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

Medicare opt-out practitioner means a *medical practitioner* who:

1. Has filed an affidavit with the Department of Health and Human Services stating that he or she will not submit any claims to Medicare during a two-year period; and
2. Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

Medicare participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

Member or Covered Person means an individual covered by the health plan including an enrollee, subscriber or policy holder.

Mental health disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Medically Necessary medical supplies mean medical supplies that are:

1. Medically Necessary to the care or treatment of an *injury or illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

Medically Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *physicians* and providers who have contracts that include an agreed upon price for health care services or expenses.

Network eligible service expense means the *eligible service expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible service expense* that is provided at and billed by a *network facility* for the services of either a *network* or *non-network provider*. *Network eligible service expense* includes benefits for *emergency health services* even if provided by a *non-network provider*.

Network provider means a *physician* or provider who is identified in the most current list for the *network* shown on *your* identification card.

Nonintensive-level services means evidence-based therapy that occurs after the completion of treatment for Intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.

Non-Network Provider means a *physician* or provider who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Other plan means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *member* is enrolled in Medicare. *Other plan* will not include Medicaid.

Out-of-pocket service expenses mean those expenses that a *member* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient*; and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient*.

Pain management program means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *member* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

Post-service claim means any claim for benefits for medical care or treatment that is not a *pre-service claim*.

Pre-service claim means any claim for benefits for medical care or treatment that requires the approval of the plan in advance of the member obtaining the medical care.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription drug deductible amount means the amount of *covered expenses*, shown in the Schedule of Benefits, if applicable, that must actually be paid during any calendar year before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *covered person* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more covered persons' *eligible expenses*.

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, OB-GYN physician or internist.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Qualified health plan or QHP means a health plan that has in effect a certification that it meets the standards issued or recognized by each Health Insurance Marketplace through which such plan is offered.

Qualified Individual means, with respect to a Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a *qualified health plan* in the individual market.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care*, nursing care, or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a cancellation or discontinuance of coverage that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:

1. Is not a *hospital*, *extended care facility*, or *rehabilitation facility*; or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

Respite care means home health care services provided temporarily to a *member* in order to provide relief to the *member's immediate family* or other caregiver.

Service area means a geographical area, made up of counties, where we have been authorized by the State of Wisconsin to sell and market our health plans. This is where the majority of our Participating Providers are located where you will receive all of your health care services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

Specialist physician means a *physician* who is not a *primary care physician*.

Spouse means *your* lawful wife or husband.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half hour to two hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

Substance abuse means alcohol, drug or chemical abuse, overuse, or dependency.

Surgery or **surgical procedure** means:

1. An invasive diagnostic procedure; or
2. The treatment of a *member's illness* or *injury* by manual or instrumental operations, performed by a *physician* while the *member* is under general or local anesthesia.

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

Terminal illness counseling means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

Terminally ill means a *physician* has given a prognosis that a *member* has six months or less to live.

Third party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term "*third party*" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term "*third party*" will not include any insurance company with a policy under which the *member* is entitled to benefits as a named insured person or an insured *dependent member* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Tobacco use or use of tobacco means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this *contract* was completed by the *member*, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Unproven service(s) means services, including medications, that are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

1. "*Well-conducted randomized controlled trials*" means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
2. "*Well-conducted cohort studies*" means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Urgent care center means a facility, not including a *hospital emergency room* or a *physician's office*, that provides treatment or services that are required:

1. To prevent serious deterioration of a *member's* health; and
2. As a result of an unforeseen *illness, injury*, or the onset of acute or severe symptoms.

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

Your *dependent members* become eligible for coverage under this *contract* on the latter of:

1. The date *you* became covered under this *contract*; or
2. The date of a newborn's birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date For Initial Dependent Members

The *effective date* for your initial *dependent members*, if any, is shown on the Schedule of Benefits. Only *dependent members* included in the application for this *policy* will be covered on your *effective date*.

Coverage for A Newborn Child

An *eligible child* born to *you* or a family *member* will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is not given within the 31 days from birth, *we* will charge an additional premium from the date of birth. If notice is given by the Marketplace within 60 days of the birth of the child, the contract may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice by the Marketplace of the child's birth.

Coverage for An Adopted Child

An *eligible child* legally placed for adoption with *you* or your *spouse* will be covered from the date of *placement* until the 31st day after *placement*, unless the *placement* is disrupted prior to legal adoption and the child is removed from your or your *spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement*.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where the issuer is notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement*.

As used in this provision, "*placement*" the assumption and retention by you or your spouse for total or partial support of the child in anticipation of the adoption of the child.

Adding Other Dependent Members

If you apply in writing for coverage on a *dependent member* and you pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent member* is covered.

ONGOING ELIGIBILITY

For All Members

A *member's* eligibility for coverage under this *contract* will cease on the earlier of:

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*; or
2. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
3. The primary Member residing outside the Service Area or moving permanently outside the Service Area of this plan.

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your *dependent member* due to divorce or if a child ceases to be an *eligible child*.

We must receive notification within 90 days of the date a *member* ceases to be an eligible *dependent member*. If notice is received by us more than 90 days from this date, any unearned premium will be credited only from the first day of the calendar month in which we receive the notice.

A *member* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

1. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on you for support.

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 15, 2014 and extends through February 15, 2015. *Qualified individuals* who enroll prior to December 15, 2014 will have an *effective date* of coverage on January 1, 2015. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2014 and January 31, 2015 will have a coverage *effective date* of the first day of the second following month.

The Health Insurance Marketplace may provide a coverage *effective date* for a *Qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, we will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special And Limited Enrollment

A *Qualified individual* has 60 days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Periods a result of one of the following events:

1. A *Qualified individual* or *dependent* loses *minimum essential coverage*;
2. A *Qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. A *Qualified individual's* enrollment or non-enrollment in a *Qualified* health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated

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- and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
5. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *Qualified* health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
 6. An individual is determined newly eligible or newly ineligible for *advance payments of the premium tax credit* or has a change in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *Qualified* health plan;
 7. A *Qualified individual* or enrollee gains access to new *Qualified* health plans as a result of a permanent move;
 8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
 - a. The qualifying events for employees are:
 - i. Voluntary or involuntary termination of employment for reasons other than gross misconduct
 - ii. Reduction in the number of hours of employment
 - b. The qualifying events for spouses are:
 - i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
 - ii. Reduction in the hours worked by the covered employee
 - iii. Covered employee's becoming entitled to Medicare
 - iv. Divorce or legal separation of the covered employee
 - v. Death of the covered employee
 - c. The qualifying events for dependent children are the same as for the spouse with one addition:
 - i. Loss of dependent child status under the plan rules
 9. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *Qualified* health plan or change from one *Qualified* health plan to another one time per month; or
 10. A *Qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where *Qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

PREMIUMS

Premium Payment

Each premium is to be paid to *us* on or before its due date. The initial premium must be paid prior to the coverage effective date.

Grace Period

When a member is receiving a premium subsidy:

After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance premium tax credits are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect advance premium tax credits on behalf of the *member* from the Department of the Treasury, and will return the advance premium tax credits on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above.

Misstatement Of Age

If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change Or Misstatement Of Residence

If *you* change *your residence*, *you* must notify *the Exchange* of *your new residence* within 60 days of the change. As a result your premium may change and *you* may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement Of Tobacco Use

The answer to the tobacco question on the application is material to *our* correct underwriting. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *contract*, *we* have the right to rerate the *contract* back to the original *effective date*.

Billing/Administrative Fees

Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a \$20 fee for any check or automatic payment deduction that is returned unpaid.

MEDICAL SERVICE BENEFITS

Deductible

The *deductible amount* means the amount of *covered service expenses* that must be paid by each/all *members* before any benefits are provided or payable. The *deductible amount* does not include any *copayment amount*.

Cost Sharing Percentage

We will pay the applicable *cost sharing percentage* in excess of the applicable *deductible amount(s)* and *copayment amount(s)* for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *member's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be provided or payable at 100%.

Refer to your Schedule of Benefits for Coinsurance Percentage and other limitations.

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *contract*; and
2. A determination of *eligible service expenses*.

The applicable *deductible amount(s)*, *cost sharing percentage*, and *copayment amounts* are shown on the Schedule of Benefits.

Note: The bill *you* receive for services or supplies from a non-*network provider* may be significantly higher than the *eligible service expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *cost sharing percentage*, *you* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Primary Care Physician

In order to obtain benefits, *you* must designate a *network primary care physician* for each *member*. *You* may select any *network primary care physician* who is accepting new patients. For children, *you* may designate a pediatrician as a *network primary care physician*. Women may designate an OB/GYN as a *network primary care physician*. However, *you* may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *member*, one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by contacting our Member Services department.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers*. *You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

You may change *your network primary care physician* by submitting a written request, online at *our* website, or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits

You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network obstetrician or gynecologist*. For all other *network specialist physicians*, you may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *contract* will be reduced.

Service Area

Ambetter operates in a limited service area. If You move from one county to another within the service area your premium may be increased or changed. If you move from one county in the service area to another that is not in the service area you are no longer eligible for coverage under this contract, and will be eligible for special enrollment into another Qualified Health Plan.

Changing The Deductible

You may increase the deductible to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

Coverage Under Other Policy Provisions

Charges for services and supplies that qualify as *covered service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *contract*.

Ambulance Service Benefits

Covered service expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness or injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses, injuries, congenital birth defects, or complications of premature birth* that require that level of care.

Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:

No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency air ambulance.
3. Air ambulance:
 - a. Outside of the 50 United States and the District of Columbia;
 - b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
 - c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. Ambulance services provided for a *member's* comfort or convenience.

Mental Health and Substance Use Disorder Benefits

Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Ambetter. If you need mental health and/or substance use disorder treatment, you may choose any provider participating in Cenpatico's provider network and do not need a referral from your PCP in order to initiate treatment. Deductibles, copayment or coinsurance amounts and

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treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and substance use disorder are included on a non-discriminatory basis for all Members for the diagnosis and *medically necessary* and active treatment of mental, emotional, and/or substance use disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

When making coverage determinations, Cenpatico utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Cenpatico utilizes “Interqual” criteria for mental health determinations and American Society of Addiction Medicine criteria for substance abuse determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not medically necessary will be made by a qualified licensed mental health professional.

Covered Inpatient, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient

1. Inpatient treatment;
2. Observation;
3. Crisis Stabilization; and
4. Electroconvulsive Therapy (ECT).

Intermediate

1. Partial Hospitalization Program (PHP);
2. Intensive Outpatient Program (IOP).

Outpatient

1. Traditional outpatient services, including individual and group therapy services;
2. Medication management services; and
3. Psychological Testing.

Expenses for these services are covered, if medically necessary and may be subject to prior authorization. Please see the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day or visit limits, if any.

Habilitation Expense Benefits

Covered service expenses shall be provided for *medically necessary Habilitation* services, including *Habilitation* services to children ages 0 to 21 with a medical diagnosis of autism spectrum disorder, which at a minimum shall include:

- a. Out-patient physical *Rehabilitation* services including speech and language therapy and/or occupational therapy, performed by a licensed therapist.
- b. Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan.
- c. Mental/behavioral health outpatient services performed by a licensed psychologist, psychiatrist, or *Physician* to provide consultation, assessment, development and oversight of treatment plans.

See the Schedule of Benefits for benefit levels or additional limits.

Home Health Care Service Expense Benefits

Covered service expenses for home health care are limited to the following charges:

1. *Home health aide services.*
2. Services of a private duty registered nurse rendered on an outpatient basis.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies.*
7. Rental of the *durable medical equipment* set forth below:
 - a. I.V. stand and I.V. tubing.
 - b. Infusion pump or cassette.
 - c. Portable commode.
 - d. Patient lift.
 - e. Bili-lights.
 - f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

Limitations:

See the Schedule of Benefits for benefit levels or additional limits for expenses related to home health aide services.

Exclusion:

No benefits will be payable for charges related to *respite care, custodial care*, or educational care.

Hospice Care Service Expense Benefits

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*.

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *member* is an *inpatient*.
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital*.
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness*.
7. *Terminal illness counseling* of the *member's immediate family*.
8. *Bereavement counseling, refer to your Schedule of Benefits.*

Exclusions And Limitations:

Any exclusion or limitation contained in the *contract* regarding:

1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program*; or

3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person*.

Rehabilitation And Skilled Nursing Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *rehabilitation* services or confinement in a *skilled nursing facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *rehabilitation* are limited to those specified in this provision.
2. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *skilled nursing facility* for:
 - a. Daily room and board and nursing services.
 - b. Diagnostic testing.
 - c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
3. *Covered service expenses* for non-provider facility services are limited to charges incurred for the professional services of *rehabilitation medical practitioners*.

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:

1. The *member* has reached *maximum therapeutic benefit*.
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily *custodial care*.

Respite Care Expense Benefits

Respite care is covered on an *inpatient or outpatient basis* to allow temporary relief to family members from the duties of caring for a Covered Person. Respite days that are applied toward the Deductible are considered benefits provided and shall apply against any Maximum Benefit limit for these services. See your Schedule of Benefits for lifetime limits.

Medical Foods

We cover medical foods and formulas when medically necessary for the treatment of Phenylketonuria (PKU).

Chiropractic Services

We cover charges for chiropractic services. These services shall be provided at the request of the enrollee who presents a condition of an orthopedic or neurological nature necessitating treatment for which falls within the scope of a licensed chiropractor.

Infertility

Covered service expenses under this benefit are provided for medically necessary diagnostic and exploratory procedures to determine infertility including surgical procedures to correct a medically diagnosed disease or condition of the reproductive organs including but not limited to treatment of the following:

- Endometriosis;
- Collapsed/clogged fallopian tubes; or
- Testicular failure

This benefit is subject to deductible and coinsurance/copayment. Refer to the Schedule of Benefits for details.

No benefits will be payable for charges related to in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder

Coverage is provided for the following when prescribed by a physician:

Intensive Level Services

Note: Benefits for intensive-level services begin after the Enrolled Dependent child turns two years of age but prior to turning nine years of age.

Benefits are provided for evidence-based behavioral intensive-level therapy for an insured with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the Enrolled Dependent child when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:

- Based upon a treatment plan developed by a qualified provider that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Enrolled Dependent child be present and engaged in the intervention.
- Implemented by qualified providers, qualified supervising provider, qualified professional, qualified therapists or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goals of the Enrolled Dependent child's treatment plan.
- Included training and consultation, participation in team meeting and active involvement of the Enrolled Dependent child's family and treatment team for implementation of the therapeutic goals developed by the team.
- The Enrolled Dependent child is directly observed by the qualified provider at least once every two months.
- Beginning after the Enrolled Dependent child is two years of age and before the Enrolled Dependent child is nine years of age.

Intensive-level services will be covered for up to four cumulative years. We may credit against any previous intensive-level services the Enrolled Dependent child received against the required four years of intensive-level services regardless of payer. We may also require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the insured received for autism spectrum disorders that was provided to the Enrolled Dependent child prior to attaining nine years of age. Evidence-based behavioral therapy that was provided to the Enrolled Dependent child for an average of 20 or more hours per week over a continuous six-month period to be intensive-level services.

Travel time for qualified providers, supervising providers, professionals, therapists or paraprofessionals is not included when calculating the number of hours of care provided per week. We are not required to reimburse for travel time.

We require that progress be assessed and documented throughout the course of treatment. We may request and review the Enrolled Dependent child's treatment plan and the summary of progress on a periodic basis.

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Non-Intensive Level Services

Non-intensive Level Services will be covered for an Enrolled Dependent child with a verified diagnosis of autism spectrum disorder for non-intensive level services that are evidence-based and are provided to an Enrolled Dependent child by a qualified provider, professional, therapist or paraprofessional in either of the following conditions:

- After the completion of intensive-level services and designed to sustain and maximize gains made during intensive level services treatment.
- To an Enrolled Dependent child who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Enrolled Dependent child's condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

- Based upon a treatment plan developed by a qualified provider, supervising provider, professional or therapist that includes 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 the Enrolled Dependent child be present and engaged in the intervention.
- Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapist or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goal of the Enrolled Dependent child's treatment plan.
- Included training and consultation, participation in team meetings and active involvement of the Enrolled Dependent child's family in order to implement the therapeutic goals developed by the team.
- Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

Non-intensive level services may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals, or qualified therapists.

We require that progress be assessed and documented throughout the course of treatment. We may request and review the Enrolled Dependent child's treatment plan and the summary of progress on a periodic basis.

Travel time for qualified providers, qualified supervising providers, qualified professional, qualified therapists or qualified paraprofessionals is not included when calculating the number of hours of care provided per week. We are not required to reimburse for travel time.

Intensive-level and Nonintensive-level services include but are not limited to speech, occupational and behavioral therapies.

The following services are not covered under the autism spectrum disorders:

- Acupuncture.
- Animal-based therapy including hippotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.
- Custodial or respite care.
- Hyperbaric oxygen therapy.
- Special diets or supplements.
- Pharmaceuticals and durable medical equipment.

Miscellaneous Major Medical Expense Benefits

Medical *covered service expenses* are limited to charges:

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1. Made by a *hospital* for:
 - a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
 - b. Daily room and board and nursing services while confined in an *intensive care unit*.
 - c. *Inpatient* use of an operating, treatment, or recovery room.
 - d. Outpatient use of an operating, treatment, or recovery room for *surgery*.
 - e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients*.
 - f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your Schedule of Benefits for limitations.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility*, including services and supplies.
3. Made by a *physician* for professional services, including *surgery*.
4. Made by an assistant surgeon. See your Schedule of Benefits for eligible limits.
5. For the professional services of a *medical practitioner*.
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies*.
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
8. For chemotherapy and radiation therapy or treatment.
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
10. For the cost and administration of an anesthetic.
11. For oxygen and its administration.
12. For *dental service expenses* when a *member* suffers an *injury*, after the *member's* effective date of coverage, that results in:
 - a. Damage to his or her natural teeth; and
 - b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. See the Schedule of Benefits for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
15. For routine patient care for patients enrolled in an *eligible cancer clinical trial*.
16. For *medically necessary* services and supplies used in the treatment of diabetes. *Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
17. For maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy*, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
18. Well Child care.
19. For the following types of tissue transplants:

- a. Cornea transplants.
 - b. Artery or vein grafts.
 - c. Heart valve grafts.
 - d. Prosthetic tissue replacement, including joint replacements.
 - e. Implantable prosthetic lenses, in connection with cataracts.
20. Family Planning for certain professional Provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
 21. Allergy testing, injections and serum.
 22. X-ray and other radiology services.
 23. Magnetic Resonance Imaging (MRI).
 24. CAT scans.
 25. Positron emission tomography (PET scanning).
 26. Blood lead tests for children under 6 years of age per the standards established by the Department of Health and Social Services to include a minimum of 2 screenings, 1 at 12 months of age and 1 at 24 months of age;
 27. Treatment for the correction of temporomandibular joint disorder if the condition is caused by congenital, developmental or acquired deformity, disease or injury;
 28. Hospital and ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided in such facilities, provided that the *member* meets one or more of the conditions under Wisconsin Statute 632.895(12) which makes some persons eligible to receive such treatment in such facilities; and
 29. General anesthesia coverage for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to a *member* if:
 - a. The *member* is a child under the age of 5.
 - b. The *member* has a chronic disability that meets all of the conditions under § 230.04(9r)(a)2. a., b. and c.
 - c. The *member* has a medical condition that requires hospitalization or general anesthesia for dental care.

Wellness Program Benefits

Benefits may be available from time to time to members for participating in certain wellness programs that we may make available in connection with this Contract. The benefits available to members for participating in the wellness programs are described on the Schedule of Benefits. You may obtain information regarding the particular wellness programs available at any given time by visiting our website at <http://ambetter.mhswi.com/> or by contacting Member Services by telephone at 1-855-745-5506. The wellness programs and benefits available at any given time are made part of this contract by this reference [and are subject to change from time to time by us through an update to wellness program information available on our website or by contacting us].

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified). If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*.
2. For one pair of foot orthotics per *covered person*.
3. For *medically necessary* genetic blood tests.
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.
9. For occupational therapy following a covered treatment for traumatic hand injuries.
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. Hearing aid treatment which include any externally wearable instruments or devices and cochlear implants, including any implantable instruments or devices designed to enhance hearing, for any *member* under 18 years of age, who is certified as deaf or hearing impaired by a *physician* or a licensed audiologist. Treatment is defined as services, diagnosis, procedures, surgery and therapy provided by a health care professional for such an *covered person* that is related to hearing aids and cochlear. Coverage of the cost for hearing aids is not required to exceed the cost of one hearing aid per ear per *member* more often than once every three years.
12. Hearing aid treatment for member over 18 years of age. Services are limited to a single purchase including repair and replacement every three years.
13. Coverage for contraceptives and services. Contraceptives is defined as drugs or devices approved by the federal food and drug administration to prevent pregnancy. Coverage includes all of the following:
 - a. Contraceptives prescribed by a health care provider.
 - b. Outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive.
 Coverage may be subject only to the exclusions, limitations, or cost-sharing provisions that apply generally to the coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices that is provided under the contract.
14. Oral Chemotherapy coverage.

Outpatient Prescription Drug Expense Benefits

Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug*, including for the treatment of biologically based mental illnesses on the same terms and conditions as any other disease or disorder.
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician*.

Notice And Proof Of Loss:

In order to obtain payment for *covered service expenses* incurred at a *pharmacy* for *prescription orders*, a notice of claim and *proof of loss* must be submitted directly to us.

Non-Covered Services And Exclusions:

No benefits will be paid under this benefit subsection for services provided or expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance.
2. For immunization agents, blood, or blood plasma.
3. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. Due to a *member's* addiction to, or dependency on foods.

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7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
 - a. Available in and *therapeutically equivalent* to another covered *prescription drug*; or
 - b. A modified version of and *therapeutically equivalent* to another covered *prescription drug*. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription.
13. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

Pediatric Vision Expense Benefits

Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year; OptiCare offers a wide range of frames that are at no cost to you.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy.
2. Two pair of glasses as a substitute for bifocals.
3. Replacement of lost or stolen eyewear
4. Any vision services, treatment or material not specifically listed as a covered service; or
5. Non-Network Providers

Vision Expense Benefits

Routine Vision Adult 19 years of age or older

Routine eye exams, prescriptions eyeglasses, and standard contact lenses are covered and are managed through OptiCare. For information regarding your specific copayments and/or deductible please refer to your specific plan information listed in the Schedule of Benefits.

You may receive one routine eye exam and eyewear once every calendar year. Eyewear includes **either** one pair of eyeglasses or initial supply of standard contacts.

- **Eyeglasses**

Covered lenses include single vision, lined bifocal, lined trifocal, or lenticular in glass or plastic.

Covered lens add-ons include standard polycarbonate lenses, scratch resistant and anti-reflective

coating. If you require a more complex prescription lens, contact OptiCare for prior authorization. Lens options such as progressive lenses, high index tints and UV coating are not covered.

For your maximum allowance for eyeglass frames please refer to your specific plan information listed in the Schedule of Benefits. Covered frames are to be selected from OptiCare's frame formulary, offering a wide range of frames that are at no cost to you.

Should you choose to select a frame that is more than your maximum benefit, you will be financially responsible for the difference.

- **Contact Lenses**

Coverage includes evaluation, fitting, and initial supply of standard contact lenses. If you elect contact lenses in lieu of glasses, please refer to your specific plan information listed in the Schedule of Benefits for your maximum allowance for contacts.

For additional information about covered vision services, participating OptiCare providers, call Member Services at 1-855-745-5506.

Non-Routine Vision Adult 19 years of age and over and Pediatric

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a participating provider (optometrist or ophthalmologist). Covered services include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision.

Excluded services for routine and non-routine vision include:

- Visual Therapy
- Any vision services, treatment or materials not specifically listed as a covered service.
- Low vision services and hardware for adults
- Out of network care, except for pre-authorized.

Preventive Care Expense Benefits

Covered service expenses are expanded to include the charges incurred by a *member* for the following preventive health services if appropriate for that *member* in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for cervical cancer and mammography
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. Covers without cost sharing:
 - a. Screening for *tobacco use*; and
 - b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
 - i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and

- ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Benefits for preventive health services listed in this provision , except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductibles*, *cost sharing percentage* provisions, and *copayment amounts* under the *contract* when the services are provided by a *network provider*.

Benefits for *covered expenses* for preventive care expense and chronic disease management benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of deductibles, coinsurance provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service that is otherwise exempt from deductibles, coinsurance provisions, and *copayment amounts*, when received from a *network provider*.

As new recommendations and guidelines are issued, those services will be considered *covered service expenses* when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Notification

As required by PHS Act section 2715(d)(4), we will provide 60 days advance notice to *you* before any material modification will become effective, including any changes to preventive benefits covered under this *contract*.

You may access *our* website or the Member Services Department at 1-855-745-5506 to get the answers to many of *your* frequently asked questions regarding preventive services. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at <http://ambetter.mhswi.com/>.

You may also access the Federal Government's website at www.healthcare.gov/center/regulations/prevention.html to obtain current information.

Newborns' And Mothers' Health Protection Act Statement Of Rights

If services provided or expenses incurred for *hospital* confinement in connection with childbirth are otherwise included as *covered Service expenses*, we will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered service expenses* incurred for a shorter stay if the attending provider (e.g., *your* physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour (or 96-hour) stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for childbirth.

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

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If we determine that a *member* is an appropriate candidate for a *listed transplant*, Medical Service Expense Benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs.
4. High dose chemotherapy.
5. Peripheral stem cell collection.
6. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*).
7. Post-transplant follow-up.
8. Transportation for the *member*, any live donor, and the *immediate family* to accompany the *member* to and from the facility where the transplant will be performed.
9. Lodging for the *member*, any live donor and the immediate family accompanying the *member* while the *member* is confined. We will pay the costs directly for transportation and lodging, however, you must make the arrangements.

Transplant Donor Expenses:

We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract*;
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant*.

Ancillary "Center Of Excellence" Service Benefits:

A *member* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence*, *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.

Non-Covered Services And Exclusions:

No benefits will be provided or paid under these Transplant Expense Benefits:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
2. For animal to human transplants.
3. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
4. To keep a donor alive for the transplant operation.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants not included under this provision as a listed transplant.
7. For a listed transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (USFDA) regulation, regardless of whether the trial is subject to USFDA oversight.

PRIOR AUTHORIZATION

Prior Authorization Required

Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member*. However, there are some *network eligible service expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *member*:

1. Receives a service or supply from a non-*network provider*;
2. Is admitted into a *network facility* by a non-*network provider*; or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider*.

How To Obtain Prior Authorization

To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *member*.

Failure To Obtain Prior Authorization

Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency*. However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits

Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract*.

Requests for Predeterminations

You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us*.
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss*.

If *we* authorize a proposed admission, treatment, or *covered service expense* by a *network provider* based upon the complete and accurate submission of all necessary information relative to an eligible *member*, *we* shall not retroactively deny this authorization if the *network provider* renders the *covered service expense* in good faith and pursuant to the authorization and all of the terms and conditions of the *network provider's* contract with *us*.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *Member* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *Member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a *member's immediate family*.
4. Any services not identified and included as *covered service expenses* under the *contract*. You will be fully responsible for payment for any services that are not *covered service expenses*.

Even if not specifically excluded by this *contract*, no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician*; and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness*, or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense*.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *member*, such as sex-change *surgery*.
6. For the reversal of sterilization and vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is a result of rape or incest).
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations or for failure to keep a scheduled appointment.
11. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
12. For stand-by availability of a *medical practitioner* when no treatment is rendered.
13. For *dental service expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Service Expense Benefits.
14. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect.
15. For diagnosis or treatment of learning disabilities.
16. For diagnosis or treatment of nicotine addiction.
17. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
18. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
19. While confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
20. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.

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21. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
22. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
23. For *experimental or investigational treatment(s) or unproven services*. The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment or unproven service* for the treatment of that particular condition.
24. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
25. As a result of an *injury or illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
26. As a result of:
 - a. An *injury or illness* caused by any act of declared or undeclared war.
 - b. The *member* taking part in a riot.
27. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
28. For or related to surrogate parenting.
29. For or related to treatment of hyperhidrosis (excessive sweating).
30. For fetal reduction surgery.
31. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
32. As a result of any *injury* sustained while at a *residential treatment facility*.
33. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.
34. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); biofeedback; blood and blood products; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
35. For court ordered testing or care unless Medically Necessary.
36. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
37. Care provided or billed by residential treatment centers or facilities.
38. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled.
39. Bariatric Surgery.

TERMINATION

Termination Of Contract

All coverage will cease on termination of this *contract*. This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date you are no longer eligible for coverage
 - i) the last day of coverage is the last day of the month following the month in which the notice is sent by us unless you request an earlier termination effective date.
3. You obtain other minimum essential coverage.

We will refund any premium paid and not earned due to *contract* termination.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *member*; otherwise,
2. By the youngest child who is a *member*.

This *contract* will be changed to a plan appropriate, as determined by *us*, to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *contract* to be continued. We will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

Discontinuance

90-Day Notice: If we discontinue offering and refuse to renew all contracts issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, we will provide a written notice to *you* at least 90 days prior to the date that we discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market we offer in *your* state at the time of discontinuance of this *contract*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If we discontinue offering and refuse to renew all individual contracts in the individual market in the state where *you* reside, we will provide a written notice to *you* and the Commissioner of Insurance at least 180 days prior to the date that we stop offering and terminate all existing individual contracts in the individual market in the state where *you* reside.

Portability Of Coverage

If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, we will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

Notification Requirements

It is the responsibility of *you* or *your former dependent member* to notify *us* within 31 days of *your* legal divorce or *your dependent member's* marriage. *You* must notify *us* of the address at which their continuation of coverage should be issued.

Benefits After Coverage Terminates

Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries*. However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss*, as defined below. The *period of extended loss* must begin before coverage of the *member* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, with the same type and level of benefits, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *contract*. In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss*, but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

REIMBURSEMENT

If a *member's illness or injury* is caused by the acts or omissions of a *third party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

However, if payment by or for the *third party* has not been made by the time we receive acceptable *proof of loss*, we will pay regular *contract* benefits for the *member's loss*. We will have the right to be reimbursed to the extent of benefits we provided or paid for the *illness or injury* if the *member* subsequently receives any payment from any *third party*. The *member* (or the guardian, legal representatives, estate, or heirs of the *member*) shall promptly reimburse us from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *member* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party*.
4. That we:
 - a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount we have provided or paid.
 - b. May give notice of that lien to any *third party* or *third party's* agent or representative.
 - c. Will have the right to intervene in any suit or legal action to protect *our* rights.
 - d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
 - e. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to us any documents we request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing us with written notice of the intent to do so.
8. To reimburse us from any money received from any *third party*, to the extent of benefits we paid for the *illness or injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That we may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse us.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

Definitions

For the purpose of this Section, the following definitions shall apply:

A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and nongroup insurance contracts; Health insuring corporation (HIC) contracts; Coverage under group or nongroup closed panel plans (whether insured or uninsured); Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan as permitted by law.
2. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; Specified disease or specified accident coverage; Supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; School accident-type coverage; Non-medical components of long term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1 and 2 above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan. This Plan means, in a COB provision the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when you have health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

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2. If you are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If you are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan is a Plan that provides health care benefits to you primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverage that are superimposed over base hospital and surgical benefits, and insurance type coverage that are written in connection with a Closed Panel Plan to provide out-of-network benefits. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan. Each Plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers you other than as a dependent, (for example as an employee, member, policyholder, subscriber or retiree) is the Primary Plan and the Plan that covers you as a dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a dependent, and primary to the Plan covering you as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan.

Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

1. For a child whose parents are married or are living together, whether or not they have ever been married:
 - a. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

- b. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
 - c. However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that Plan.
- 2. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - a. If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
 - b. If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of paragraph a. above shall determine the order of benefits;
 - c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of paragraph a. above determine the order of benefits; or
 - d. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial Parent, first;
 - The Plan covering the spouse of the Custodial Parent, second;
 - The Plan covering the noncustodial parent, third; and then
 - The Plan covering the spouse of the noncustodial parent, last.
- 3. For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of paragraph a. or b. above shall determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee

The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a dependent of an active employee and you are a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

COBRA or State Continuation Coverage

If Your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering you as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

Longer or Shorter Length of Coverage

The Plan that covered you as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must calculate the benefits it would have paid in the absence of other health care

coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. If you are enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering you. We need not tell, or get the consent of, any person to do this. You, to claim benefits under This Plan, must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by us is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid, or any other person or organization that may be responsible for the benefits or services provided for you. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at 1-855-745-5506 or <http://ambetter.mhswi.com/>. You should also refer to the Complaint and Appeals procedures. If you are still not satisfied, you may call the Wisconsin **Office of the Commissioner of Insurance** for instructions on filing a consumer complaint.

CLAIMS

Notice Of Claim

We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

Proof Of Loss

You or your covered *dependent member* must give us written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year after the time proof is otherwise required will not be accepted, unless you or your covered *dependent member* had no legal capacity in that year.

Cooperation Provision

Each *member*, or other person acting on his or her behalf, must cooperate fully with us to assist us in determining *our* rights and obligations under the *contract*.

Time For Payment Of Claims

Benefits will be paid within 30 days after receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits within 45 days after receipt of *proof of loss*. If we do not pay within such period, we shall pay interest at the rate of 12 percent per annum from the 30th day after receipt of such proof of loss to the date of late payment.

Payment Of Claims

Except as set forth in this provision, all benefits are payable to you. Any accrued benefits unpaid at your death, or your *dependent member's* death may, at our option, be paid either to the beneficiary or to the estate. If any benefit is payable to your or your *dependent member's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, we may pay up to \$1,000 to any relative who, in our opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *contract* for *hospital*, surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Any payment made by us in good faith under this provision shall fully discharge our obligation to the extent of the payment. We reserve the right to deduct any overpayment made under this *contract* from any future benefits under this *contract*.

Foreign Claims Incurred For Emergency Care

Claims incurred outside of the United States for *emergency* care and treatment of a *member* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

Assignment

We will reimburse a *hospital* or health care provider if:

1. Your health insurance benefits are assigned by you in writing; and
2. We approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without our approval, shall not confer upon such *hospital* or person, any right or privilege granted to you under the *contract* except for the right to receive benefits, if any, that we have determined to be due and payable.

Custodial Parent

This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing

custody. The custodial parent, who is not a *member*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *contract*;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

Legal Actions

No suit may be brought by *you* on a claim sooner than 60 days after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *contract* for any reason unless the *member* first completes all the steps in the complaint/*appeal* procedures made available to resolve disputes in *your* state under the *contract*. After completing that complaint/*appeal* procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your* complaint/*appeal*.

How To Contact Us

MHS Health Wisconsin
10700 Research Drive.
Milwaukee, WI 53226

1-855-745-5506, twenty-four hours per day, seven days a week.

GRIEVANCE PROCEDURES

Applicability/Eligibility

These *grievance* procedures apply to any hospital or medical policy or certificate or conversion plans, but not to accident only or disability only insurance.

An Eligible grievant is:

1. A member;
2. Person authorized to act on behalf of the member. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format;
3. In the event the member is unable to give consent: a spouse, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the member.

Grievances

Members have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Members have the right to review the claim file and to present evidence and testimony as part of the internal review process.

Grievances will be promptly investigated and presented to the internal *grievance* panel. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.

Resolution Timeframes

1. *Grievances* regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if we provide the *member* and the *member's* authorized representative, if applicable, written notification of the following within the first 30 calendar days:
 - a. That we have not resolved the *grievance*;
 - b. When our resolution of the *grievance* may be expected; and
 - c. The reason why the additional time is needed.
2. All other *grievances* will be resolved and we will notify the *member* in writing with the appeal decision within the following timeframes:
 - a. Post-service claim: within 60 calendar days after receipt of the *member's* request for internal appeal;
 - b. Pre-service claim: within 30 calendar days after receipt of the *member's* request for internal appeal.

A member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the member's claim for benefits. All comments, documents, records and other information submitted by the member relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The member will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the member 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the member will have the option of delaying the determination for a reasonable period of time to respond to the new information;

2. The member will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the member 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the member will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Refer to a later section for information regarding internal *expedited grievances*.

Acknowledgement

Within five business days of receipt of a *grievance*, a written acknowledgment to the member or the member's authorized representative confirming receipt of the *grievance* must be delivered or deposited in the mail.

When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

1. The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose;
2. If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*; and
3. A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.

Right to Appear

The member who filed the *grievance*, or the member's authorized representative, has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

1. Written notification must be sent to the member indicating the time and place of the *grievance* panel meeting at least seven calendar days before the meeting;
2. Reasonable accommodations must be provided to allow the member, or the member's authorized representative, to participate in the *grievance* panel.

Grievance Panel

The *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

1. At least one individual authorized to take corrective action on the *grievance*; and
2. At least one insured other than the grievant, if an insured is available to serve on the *grievance* panel. The insured member of the panel shall not be an employee of the plan, to the extent possible.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed health care provider with expertise in the field relating to the *grievance* and who was not consulted in connection with the original *adverse benefit determination*.

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the member and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *member's* health condition requires but not more than 72 hours after receipt of the *grievance*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited grievances*.

Upon written request, we will mail or electronically mail a copy of the member's complete policy to the member or the member's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.

The panel's written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;
3. The signature of one voting member of the panel; and
4. A written description of position titles of panel members involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
 - a. A clear explanation of the decision;
 - b. Reference to the specific plan provision on which the determination is based;
 - c. A statement that the member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the member's claim for benefits.
 - d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the member upon request;
 - e. If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
 - g. The date of service;
 - h. The health care provider's name;
 - i. The claim amount;
 - j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
 - k. The health plan's denial code with corresponding meaning;
 - l. A description of any standard used, if any, in denying the claim;
 - m. A description of the external review procedures, if applicable;
 - n. The right to bring a civil action under state or federal law;
 - o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
 - p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
 - q. A culturally linguistic statement based upon the member's county or state of residence that provides for oral translation of the *adverse benefit determination*, if applicable.

Complaints received from the Wisconsin Insurance Department

The commissioner may require *us* to treat and process any *complaint* received by the Wisconsin Insurance Department by, or on behalf of, a member as a *grievance* as appropriate. *We* will process the Wisconsin Insurance Department *complaint* as a *grievance* when the commissioner provides *us* with a written description of the *complaint*.

INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW

Overview

If you need help: *If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact MHS Health Wisconsin at the Member Services Department, 10700 Research Drive, Milwaukee, WI 53226, by telephone at 1-855-745-5506, by fax at 1-844-784-2438 or <http://ambetter.mhswi.com/>.*

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, *you* have already received (post-service claim denial) or denies *your* request to authorize treatment or service (pre-service denial), *you*, or someone *you* have authorized to speak on *your* behalf (an authorized representative), can request an appeal of the plan's decision. If the plan rescinds *your* coverage or denies *your* application for coverage, *you* may also appeal the plan's decision. When the plan receives *your* appeal, it is required to review its own decision. When the plan makes a decision, it is required to notify *you* (provide notice of an *adverse benefit determination*) including:

- The reasons for the plan's decision;
- *Your* right to file appeal the decision
- *Your* right to request an *external review*; and
- The availability of a Consumer Assistance Program at The Wisconsin **Office of the Commissioner of Insurance**.
- If *you* do not speak English, *you* may be entitled to receive appeals' information in *your* native language upon request.
- When *you* request an *internal appeal*, the plan must give *you* its decision as soon as possible, but no later than:
 - 72 hours after receiving *your* request when *you* are appealing the denial for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal appeal and external reviews take place at the same time.)
 - 30 days for appeals of denials of non-urgent care *you* have not yet received.
 - 60 days for appeals of denials of services *you* have already received (post-service denials).
 - No extensions of the maximum time limits will be permitted without *your* consent.

Continuing Coverage: *The plan cannot terminate your benefits until all of the appeals have been exhausted. However, if the plan's decision is ultimately upheld, you may be responsible for paying any outstanding claims or reimbursing the plan for claims' payments it made during the time of the appeals.*

Cost and Minimums for Appeals: There is no cost to *you* to file an appeal and there is no minimum amount required to be in dispute.

Defined terms: Any terms appearing in *italics* are defined at the end of these provisions.

Emergency medical services: If the plan denies a claim for an emergency medical service, *your* appeal will be handled as an *expedited appeal*. *The plan will advise you at the time it denies the claim that you can file an expedited internal appeal. If you have filed for an expedited internal appeal, you may also file for an expedited external review (see "Simultaneous urgent claim, expedited internal review and external review").*

Your rights to file an appeal of denial of health benefits: *You or your authorized representative, such as your health care provider, may file the appeal for you, in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an appeal by telephone:*

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MHS Health Wisconsin at the Appeals Unit, 10700 Research Drive. Milwaukee, WI 53226, by telephone at 1-855-745-5506, by fax at 1-844-784-2438 or <http://ambetter.mhswi.com/>. Please include in *your* written appeal or be prepared to tell us the following:

- Name, address and telephone number of the insured person;
- The insured's health plan identification number;
- Name of health care provider, address and telephone number;
- Date the health care benefit was provided (if a post-claim denial appeal)
- Name, address and telephone number of an *authorized representative* (if appeal is filed by a person other than the insured); and
- A copy of the notice of *adverse benefit determination*.

Rescission of coverage: If the plan rescinds (withdraws) *your* coverage, *you* may file an appeal according to the following procedures. The plan cannot terminate *your* benefits until all of the appeals have been exhausted. Since a rescission means that no coverage ever existed, if the plan's decision to rescind is upheld, *you* will be responsible for payment of all claims for *your* health care services.

Time Limits for filing an internal claim or appeal: *You* must file the internal appeal within 180 days of the receipt of the notice of claim denial (an adverse benefit determination). Failure to file within this time limit may result in the company's declining to consider the appeal.

Time Limits for an External Appeal: *You* have 120 days to file for an *external review* after receipt of the plan's *final adverse benefit determination*.

Your Rights to a Full and Fair Review. The plan must allow *you* to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

- The plan must provide *you*, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give *you* a reasonable opportunity to respond prior to that date; and
- The adverse determination must be written in a manner understood by *you*, or if applicable, *your* authorized representative and must include all of the following:
 - a) The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
 - b) Information sufficient to identify the claim involved, including the date of service, the health care provider;
 - c) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and
 - d) Your right to an independent internal review
- As a general matter, the plan may deny claims at any point in the administrative process on the basis that it does not have *sufficient information*; such a decision, however, will allow *you* to advance to the next stage of the claims process.

Other Resources to help you

Wisconsin Office of the Commissioner of Insurance: For questions about *your* rights or for assistance *you* may also contact the Consumer Services Division at the **Wisconsin Office of the Commissioner of Insurance**. 1-800-236-8517.

Language services are available from the health benefit plan and from The **Wisconsin Office of the Commissioner of Insurance**.

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Your rights to appeal and the instructions for filing an appeal are described in the provisions following this Overview.

INTERNAL CLAIMS AND APPEALS

Non-urgent, pre-service claim denial

For a non-urgent *pre-service claim*, the plan will notify *you* of its decision as soon as possible but no later than 15 days after receipt of the claim.

If the plan needs more time, it will contact *you*, in writing, telling *you* the reasons why it needs more time and the date when it expects to have a decision for *you*, which should be no later than 15 days.

If the plan needs additional information from *you* before it can make its decision, it will provide a notice to *you*, describing the information needed. *You* will have 45 days from the date of the plan's notice to provide the information. If *you* do not provide the additional information, the plan can deny *your* claim. In which case, *you* may file an appeal.

The plan must make its decision within 48 hours after receipt of the information or at the end of the 45 days, whichever comes first.

Urgent Pre-service Care claim denial

If your claim for benefits is urgent, you or your authorized representative, or your health care provider (physician) may contact us with the claim, orally or in writing.

If the claim for benefits is one *involving urgent care*, we will notify *you* of our decision as soon as possible, but no later than 72 hours after we receive *your* claim provided *you* have given us information sufficient to make a decision.

To assure *you* receive notice of our decision, we will contact *you* by telephone or facsimile (fax) or by another method meant to provide the decision to *you* quickly.

In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. **However, if a physician with knowledge of *your* medical condition determines that a claim involves urgent care, or an emergency, the claim must be treated as an urgent care claim.**

Simultaneous urgent claim and expedited internal review:

In the case of a claim involving urgent care, *you* or *your* authorized representative may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by the member; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the member by telephone, facsimile, or other expeditious method.

Simultaneous urgent claim, expedited internal review and external review:

You, or *your* authorized representative, may request an expedited external review if both the following apply

1. *You* have filed a request for an expedited internal review; and
2. After a final adverse benefit determination, either of the following applies:
 - (a) *Your* treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of *you*, or would jeopardize *your* ability to regain maximum function, if treated after the time frame of a standard external review; or
 - (b) The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which *you* received emergency services, but have not yet been

discharged from a facility.

Concurrent Care Decisions

Reduction or termination of ongoing plan of treatment: If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we notify *you* that we have decided to reduce or terminate the treatment, we will give *you* notice of that decision allowing sufficient time to appeal the determination and to receive a decision from us before any interruption of care occurs.

Request to extend ongoing treatment: If *you* have received approval for an ongoing treatment and wish to *extend the treatment* beyond what has already been approved, we will consider *your* appeal as a request for urgent care. If *you* request an extension of treatment at least 24 hours before the end of the treatment period, we must notify *you* soon as possible but no later than 24 hours after receipt of the claim.

An appeal of this decision is conducted according to the urgent care appeals procedures.

Concurrent urgent care and extension of treatment: Under the concurrent care provisions, any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the member within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a pre-service claim or a post-service claim.

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Post-service appeal of a claim denial (retrospective)

If *your* appeal is for a *post-service claim denial*, we will notify *you* of our decision as soon as possible but no later than 60 days after we have received *your* appeal. If we need more time, we will contact *you*, telling *you* about the reasons why we need more time and the date when we expect to have a decision for *you*, which should be no later than 14 days, provided that we determine that such an extension is necessary due to matters beyond our control, and we notify *you* prior to the expiration of the initial 30 days period. If the reason we need more time to make a decision is because *you* have not given us necessary information, *you* will have 45 days from the date we notify *you* to give us the information. We will describe the information needed to make our decision in the notice we send *you*. This is also known as a “retrospective review.” The plan will notify *you* of its determination as soon as possible but no later than 5 days after the benefit determination is made.

The plan will let *you* know before the end of the first 30 day period, explaining the reason for the delay, requesting any additional information needed, and advising *you* when a final decision is expected. If more information is requested, *you* have at least 45 days to supply it. The claim then must be decided no later than 15 days after *you* supply the additional information or the period given by the plan to do so ends, whichever comes first. The plan must get *your* consent if it wants more time after its first extension. The plan must give *you* notice that *your* claim has been denied in whole or in part (paying less than 100% of the claim) before the end of the time allotted for the decision.

EXTERNAL REVIEW

Right to External Review

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Under certain circumstances, *you* have a right to request an external review of our adverse benefit decision by an independent review organization or by the commissioner of insurance, or both.

If *you* have filed internal claims and appeals according with the procedures of this plan, and the plan has denied or refused to change its decision, or if the plan has failed, because of its actions or its failure to act, to provide *you* with a *final determination* of *your* appeal within the time permitted, or if the plan waives, in writing, the requirement to exhaust the internal claims and appeals procedures, *you* may make a request for an *external review* of an *adverse benefit determination*.

All requests for an *external review* must be made within 180 days of the date of the notice of the plan's *final adverse benefit determination*. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including experimental/investigational, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan no later than 5 days after the initial request was made.

You may file the request for an external review by contacting the plan

MHS Health Wisconsin at the Appeals Unit, 10700 Research Drive, Milwaukee, WI 53226, by telephone at 1-855-745-5506, by fax at 1-844-784-2438 or <http://ambetter.mhswi.com/>. **Non-urgent request for an external review**

Unless the request is for an expedited external review, the plan will initiate an external review within 5 days after it receives *your* written request if *your* request is complete. The plan will provide *you* with notice that it has initiated the external review that includes:

(a) The name and contact information for the assigned independent review organization or the commissioner of insurance, as applicable, for the purpose of submitting additional information; and

(b) Except for when an expedited request is made, a statement that *you* may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the independent review organization or the commissioner of insurance to consider when conducting the external review.

If your request is not complete, the plan will notify *you* in writing and include information about what is needed to make the request complete.

If the plan denies your request for an external review on the basis that the adverse benefit determination is not eligible for an external review, the plan will notify *you*, in writing, the reasons for the denial and that *you* have a right to appeal the decision to the commissioner of insurance.

If the plan denies your request for an external review because you have failed to exhaust the Internal Claims and Appeals Procedure, *you* may request a written explanation, which the plan will provide to *you* within 10 days of receipt of *your* request, explaining the specific reasons for its assertion that *you* were not eligible for an *external review* because *you* did not comply with the required procedures.

If the OCI upholds the plan's decision: If *you* file a request for an external review with the **OCI**, and if the **OCI** upholds the plan's decision to deny the *external review* because *you* did not follow the plan's internal claims and appeals procedures, *you* must resubmit *your* appeal according to the plan's internal claims and appeals procedures within 10 days of the date of *your* receipt of the commissioner's decision. The clock will begin running on all of the required time periods described in the internal claims and appeals procedures when *you* receive this notice from the commissioner.

If the plan's failure to comply with its obligations under the internal claims and appeals procedures was considered (i) *de minimis*, (ii) not likely to cause prejudice or harm to *you* (member), (iii) because we had a good reason or our failure was caused by matters beyond our control (iv) in the context of an ongoing good-faith exchange of information between the plan and *you* (member) or *your authorized representative* and (v)

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not part of a pattern or practice of our not following the internal claims and appeals procedures, then *you* will not be deemed to have exhausted the internal claims and appeals requirements. *You* may request an explanation of the basis for the plan's asserting that its actions meet this standard.

Expedited external review for experimental and/or investigational treatment: *You* may request an external review of an adverse benefit determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit under the terms of the health benefit plan.

To be eligible for an external review under this provision, *your* treating physician shall certify that one of the following situations is applicable:

1. Standard health care services have not been effective in improving *your* condition;
2. Standard health care services are not medically appropriate for *you*; or
3. There is no available standard health care service covered by the health plan issuer that is more beneficial than requested health care service.

The request for an expedited external review under this provision may be requested orally or by electronically. For Expedited/Urgent requests, *your* health care provider can orally make the request on *your* behalf.

Independent Review Organization: An *external review* is conducted by an independent review organization (IRO) selected on a random basis as determined in accordance with Wisconsin law. The IRO will provide *you* with a written notice of its decision to either uphold or reverse the plan's *adverse benefit determination* within 30 days of receipt of a *standard external review (not urgent)*.

If an *expedited external review (urgent)* was requested, the IRO will provide a determination as soon as possible or within 72 hours of receipt of the expedited request. The IRO's decision is binding on the company. If the IRO reverses the health benefit plan's decision, the plan will immediately provide coverage for the health care service or services in question.

If the commissioner or IRO requires additional information from *you* or *your* health care provider, the plan will tell *you* what is needed to make the request complete.

If the plan reverses its decision: If the plan decides to reverse its adverse determination before or during the external review, the plan will notify *you*, the IRO, and the commissioner of insurance within one business day of the decision.

After receipt of health care services: No expedited review is available for adverse benefit determinations made after receipt of the health care service or services in question.

Emergency medical services: If plan denies coverage for an emergency medical service, the plan will also advise at the time of denial that *you* request an expedited internal and *external review* of the plan's decision.

Review by the Office of the Commissioner of Insurance: If the plan has made an adverse benefit determination based on a contractual issue (e.g., whether a service or services are covered under *your* contract of insurance), *you* may request an external review by the **Office of the Commissioner of Insurance**.

If the IRO and OCI uphold the plan's decision, *you* may have a right to file a lawsuit in any court having jurisdiction.

Definitions

Adverse benefit determination means any of the following:

Adverse benefit determination means a decision by a health plan issuer:

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1. To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
 - a. A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
 - b. A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;
 - c. A determination that a health care service is not a covered benefit;
 - d. The imposition of an exclusion, including an exclusion for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
2. Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;
3. To rescind coverage on a health benefit plan.

a denial, reduction, or termination of, or

a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or

failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, 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 review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary.

An "adverse benefit determination" also includes a rescission of the participant or beneficiary.

Ambulatory review means utilization review of health care services performed or provided in an outpatient setting.

Authorized representative means an individual who represents *you* in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- (1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- (2) A person authorized by law to provide substituted consent for a covered individual;
- (3) A family member but only when *you* are unable to provide consent.

Claim involving urgent care means any claim for Medicare care or treatment with respect to the application of the time periods for making non-urgent care determinations

- Could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or,
- In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment is the subject of the claim.

The determination whether a claim is a "claim involving urgent care" will be determined by the plan; or, by a physician with knowledge of the member's medical condition.

You means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "*You*" does include *your* authorized representative with regard to an internal appeal or external review in accordance with division (C) of this section. "*You*" does not include *your* representative in any other context.

De minimis means something not important; something so minor that it can be ignored.

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Emergency medical condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Emergency services means the following:

1. A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
2. Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.
3. As used when referring to *emergency services* or *emergency medical condition*, “Stabilize” means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of an individual’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:
 - a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
 - 1) Serious impairment to bodily functions;
 - 2) Serious dysfunction of any bodily organ or part.
 - b) In the case of a woman having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.
 - c) *Transfer* has the same meaning as in section 1867 of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C.A. 1395dd, as amended.

Final adverse benefit determination means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

Health care professional means a physician, psychologist, nurse practitioner, or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

Health care provider or *provider* means a health care professional or facility.

Independent review organization (IRO) means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of adverse benefit determinations and by the commissioner of insurance in accordance with Wisconsin law.

Language assistance means translation services provided if requested. Contact customer service at 1-855-745-5506 if oral or written services are needed.

(1) The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(2) The plan or issuer must provide, upon request, a notice in any applicable non-English language; and

(3) The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

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Applicable non-English language. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

Medical care means the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation primarily for and essential to the provision of such care.

Post-service claim means any claim for a benefit under a group health plan that is not a “pre-service claim.”

Pre-service claim means any claim for a benefit under a group health plan, with respect to which the terms of the plan condition receipt of the benefit, in completely or in part, on approval of the benefit in advance of obtaining medical care.

Physician means a provider who holds a certificate under Wisconsin law authorizing the practice of medicine and surgery or osteopathic medicine and surgery or a comparable license or certificate from another state.

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. “Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage

Urgent care claims: If your claim involves *urgent care*, we will notify you as soon as possible but no later than 72 hour after we have received the appeal for a denied claim for urgent care.

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application, Schedule of Benefits and any rider-amendments is the entire contract between *you* and *us*. No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract*. No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver

If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract*, that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions

No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member*;
2. A copy of the application, and any amendments, has been furnished to the *member(s)*, or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member*. A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment For Fraud, Misrepresentation Or False Information

During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *contract*.

Conformity With State Laws

Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Hold Harmless

MHS Health Wisconsin Plan is not a member of any guaranty fund, and in the event that *we* become insolvent, *member* is protected only to the extent that the hold harmless provision under 1751.13 applies to those health care services rendered.

In addition, in the event *we* become insolvent, the *member* may be financially responsible for health care services rendered by a provider or health care facility that is not under contract with *us*. However, the *member* is protected only to the extent that the hold harmless provision under 1751.13 applies to those health care services rendered.