



**Health Insurance Risk Sharing Plan (HIRSP)**

1751 West Broadway,  
P.O. Box 8961  
Madison, Wisconsin 53708-8961  
(800) 828-4777 or (608) 221-4551

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**Policy of the Health Insurance Risk-Sharing Plan**

**REVISED JANUARY 1, 2010**

**Important Notice**

You should review your copy of the HIRSP application form. Omissions or misstatements in the application form could cause HIRSP to deny otherwise valid claims. Carefully check the form and write to HIRSP at the above address within 10 days of receiving this policy if:

- A. Any information shown on the form is not correct and complete.
- B. Any requested medical history has not been included.

HIRSP issued the insurance coverage based on the information given in the application.

**If you are not satisfied with this policy, you may send it back to HIRSP, and HIRSP will return the premium. You must do this within 10 days of receiving this policy mailing. This policy will then be considered as never having been in force.**

HIRSP issues this policy to you in accordance with Wisconsin law. The paid premium and completed application put this policy in force as of the policy effective date.

**HIRSP may change the premium, change this policy, or decline renewal of this policy only as stated under Section I. Term and Renewal Agreement, Section II. Premium Change, and Section III. Policy Change.**



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## **Section I. Term and Renewal Agreement**

Coverage starts on the policy effective date at 12:01 a.m. and ends on the policy renewal date at 12:01 a.m. Each time you renew this policy by paying the premium within the 31-day grace period, the new term begins when the old term ends.

HIRSP will terminate coverage the day you:

- A.** are eligible for employer-offered coverage, which may include a group health plan or health insurance;
- B.** receive a payment or reimbursement for a HIRSP premium, HIRSP medical deductible, HIRSP medical coinsurance, or HIRSP drug coinsurance amount from a federal, state, county, or municipal government, or one of its agencies. This does not apply to the statutorily exempt state programs for the following:
  - 1.** Vocational rehabilitation.
  - 2.** Renal disease.
  - 3.** Hemophilia.
  - 4.** Cystic fibrosis.
  - 5.** Maternal and child health services.
  - 6.** Human immunodeficiency virus (HIV);
- C.** are no longer a resident of Wisconsin;
- D.** are eligible for Medicaid, including BadgerCare Plus, except as specifically stated in s. 149.12, as amended.
- E.** are eligible for Medicare and do not enroll in Part A, Part B and Part D.

If this policy is canceled or not renewed, HIRSP will return the unused premium to you.

HIRSP must receive the premium on or before the date it is due or within the 31 days that follow.

If you fail to pay your premium timely or if you voluntarily end your HIRSP coverage, you are required to wait 12 months from your termination date to reapply.

## **Section II. Premium Change**

The premium for this policy is subject to change. Premium changes are made only on the policy renewal date that coincides with, or next follows, the effective date of the new rate.

HIRSP can revise rates only if it does so on all policies, with the same provisions and benefits, issued to people of the same classification in the same geographic area. If HIRSP increases the premium rate for everyone in a plan by 25% or more, HIRSP will give you 60 days advance notice.

## **Section III. Policy Change**

Any provision of this policy is subject to change as mandated by the State of Wisconsin. You will receive written notice of any benefit reductions at least 60 days before the policy renewal date.

## **Section IV. General Information**

### **A. General Description of Coverage**

HIRSP offers the following five insurance plans:

1. HIRSP 1,000 is a \$1,000 deductible plan;
2. HIRSP 2,500 is a \$2,500 deductible plan;
3. HIRSP 5,000 is a \$5,000 deductible plan;
4. HIRSP Medicare Supplement is a \$500 deductible plan for individuals who are eligible and enrolled in Medicare Parts A, B, and D; and
5. HIRSP Health Savings Account is a \$2,500 or \$3,500 deductible plan.

Once each calendar year HIRSP will notify you of your right to change your HIRSP plan. This is the only time during the year that you may change your coverage. You may request a change between HIRSP 1,000, HIRSP 2,500, HIRSP 5,000 and HIRSP Health Savings Account - \$2,500 deductible or HIRSP Health Savings Account - \$3,500 deductible. The requested change will be effective January 1 of the next calendar year if you notify HIRSP before November of the current calendar year. If you do not notify HIRSP before November 1st, your current coverage option will remain in effect for the next calendar year.

You are required to notify HIRSP when you become eligible for Medicare.

### **B. Coverage**

Coverage is subject to terms, conditions, exclusions, limitations and all other provisions of this policy. This document describes all terms, conditions, exclusions and provisions of this policy that apply to the HIRSP 1,000, HIRSP 2,500, HIRSP 5,000 and HIRSP Medicare Supplement plans.

### **C. How to Use This Policy**

This policy, including all endorsements, should be read carefully and completely by you. You should also review this policy periodically. The provisions of this policy are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a clear understanding of your coverage under this policy.

Each term used in this policy has a special meaning. These terms are defined for you in Section V. Definitions. By understanding these definitions, you will have a clearer understanding of your coverage as described in this policy.

From time to time, this policy may be amended. When that happens, a new policy or new endorsement for this policy will be made available online for each policyholder. That means your coverage under this policy will change to the extent described in the new policy or endorsement, as of the effective date of that new policy or endorsement.

This policy should be kept in a safe place for your future reference.

### **D. Covered Services.**

Benefits are payable only for covered services under this policy. The fact that a physician has performed or prescribed a health care service or the fact that it may be the only available health care service for an illness or injury does not mean that the health care service is covered under this policy. HIRSP Authority has the sole and exclusive right to interpret and apply this policy's terms, conditions, limitations, exclusions and all other provisions of this policy, including, but not limited to, making factual determinations under this policy's provisions, including, but not limited to, whether benefits are payable. At any time, HIRSP Authority may, at its sole discretion, give certain discretionary authority to other persons or entities providing administrative services to HIRSP in regard to this policy. HIRSP Authority

reserves the right to change, interpret, modify, remove or add benefits at its sole discretion, subject to the notice requirements stated in Section XII. J. Other than HIRSP Authority, no person or entity has any authority to make any oral changes or amendments to this policy.

In certain circumstances for purposes of overall cost savings or efficiency, HIRSP may at its sole discretion, pay benefits for health care services which are not covered under this policy, to the limited extent provided in Section IX. B. 2. Alternative Care. The fact that HIRSP makes such payment in any particular case shall not in any way be deemed to require HIRSP to make such payment in any other case, whether similar or dissimilar.

HIRSP Authority may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to this policy, including claims processing and utilization review management services. Their identity and the nature of the services being provided by them may be changed by HIRSP Authority at any time at its sole discretion, and without giving prior notice to you or getting your approval. By accepting this policy, you agree to and must cooperate fully with those persons or entities in the performance of their responsibilities.

#### **E. Prior Approval of Health Care Services**

This subsection only applies to those participants enrolled in HIRSP 1,000, HIRSP 2,500 or HIRSP 5,000.

The Plan Administrator's prior approval is required in order to receive benefits for charges for covered expenses for certain health care services covered under this policy. Health care services requiring the Plan Administrator's prior approval are listed below. You are responsible for assuring that the required prior approval is received before health care services are provided by calling 1-866-841-6572 or faxing the request for prior approval to 1-608-226-4777. Failure to comply with the prior approval requirements, excluding paragraph 7. below, will result in no coverage for such health care services.

To assure that health care services are covered, you must obtain the Plan Administrator's prior approval before you receive any of the following health care services:

1. Surgical services for morbid obesity;
2. Reduction mammoplasty, septoplasty, and blepharoplasty;
3. Transplant services;
4. Any durable medical equipment that will be rented for more than three months or with a purchase price greater than \$1,500;
5. Any prosthetic with a purchase price greater than \$1,500;
6. Pain management procedures as follows: (a) percutaneous intervertebral disc procedures (intradiscal electrothermal therapy (IDET), intradiscal electrothermal annuloplasty (IDEA), percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), nucleoplasty, laser assisted disc decompression (LADD), percutaneous disc decompression, chemonucleolysis; (b) radiofrequency neuroablation (neurolysis) of the facet joint nerves; (c) facet joint injections and medial branch nerve blocks; (d) trigger point injections; (e) epidural injections, other than epidural injections provided to the pregnant participant in connection with labor or delivery of a newborn child or due to surgery; (f) sacroiliac joint injections; and (g) artificial intervertebral disc replacement (lumbar artificial disc replacement (LADR) and intervertebral disc prosthesis).
7. The following additional health care services, except when such services are provided in an emergency:
  - a. Spinal surgeries;
  - b. PET scans;
  - c. MRA studies;

- d. Dental repair related to an injury;
- 8. Inpatient admissions. Approval must be received for non-emergency admissions, at least three business days prior to the confinement. Please see Section X. for the procedures to obtain hospital admission authorization in order to avoid a penalty;
- 9. Outpatient visits and transitional treatment arrangements for treatment of alcoholism, drug abuse and nervous or mental disorders beyond 50 visits per calendar year;
- 10. Spinal cord stimulators;
- 11. Implantable infusion pain pump.
- 12. Intravenous (IV) therapy/infusion therapy performed in your home when prescribed by a physician. Home IV therapy or home infusion therapy includes, but is not limited to, injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), and antibiotic therapy;
- 13. Genetic testing services for treatment of an illness.

New medical or biomedical technology or new surgical methods or techniques may be experimental. You are strongly encouraged to seek prior approval for these health care services to ensure they are payable under this policy.

If you don't obtain the Plan Administrator's prior approval before you receive any health care service listed above, benefits for that health care service will not be payable under this policy. This paragraph does not apply to inpatient non-emergency admissions stated in 7. above. For inpatient non-emergency admissions, benefits will be reduced by \$500 if you or your family member, physician, hospital or other health care provider on your behalf fails to notify the Plan Administrator of the proposed hospitalization in advance as required in Section X.

After the Plan Administrator receives a prior approval request, the Plan Administrator will make a determination on whether or not to approve benefits for the health care service based upon the information available to the Plan Administrator at the time the Plan Administrator receives the prior approval request. The Plan Administrator will send you its written response to the request, telling you whether the health care service is covered.

However, even if a health care service is approved in writing by the Plan Administrator, no benefits will be paid unless, after receiving the proof of claim, the Plan Administrator determines that benefits are payable for that approved health care service under the terms, conditions, exclusions, limitations, and all other provisions of this policy, and your coverage is in effect at the time the health care service is provided to you and the health care services are provided by a Medicaid-certified health care provider. Even if a health care service is approved by the Plan Administrator under this subsection and provided by a Medicaid-certified provider, benefits are still subject to all terms, conditions and provisions of this policy.

The proof of claim may differ from the prior approval request. This means that the Plan Administrator's approval of benefits is not its final decision and does not guarantee payment of benefits later. This means that benefits may not be paid if, after reviewing the proof of claim, the Plan Administrator determines that the health care service is not covered under this policy.

If you or your physician disagrees with the Plan Administrator's decision, you may request a review in accordance with the provisions in Section XII. P. Grievance Procedure.

#### **F. Newborn Child Coverage**

A newborn child is only eligible for HIRSP coverage if he/she is not eligible for coverage under Medicaid or the BadgerCare Plus Standard Plan. Before coverage is available under this subsection, the Plan Administrator must receive proof acceptable to the Plan Administrator that the newborn child is not eligible for Medicaid or the BadgerCare Plus Standard Plan.

HIRSP will cover a newborn natural child born to a policyholder from the moment of that child's birth and for the next 60 days of that child's life immediately following that child's date of birth, provided the Plan Administrator receives proof acceptable to the Plan Administrator that the newborn child is not eligible for Medicaid or the BadgerCare Plus Standard Plan.

Prior to the end of that 60-day period, the policyholder must: (1) notify the Plan Administrator about the child's birth; and (2) pay the required premium for that child's coverage during that child's 60-day period.

If the policyholder fails to notify the Plan Administrator and pay the required premium, coverage for his/her newborn natural child shall terminate at the end of that 60-day period, unless the policyholder applies for coverage as described below. If the policyholder does not apply for coverage and pay the required premium as described below, the Plan Administrator may reduce any future benefit payments for which HIRSP is liable under this policy on your claims by the amount of the required premium for that child's coverage during that 60-day period.

If a policyholder wishes to apply for coverage for his/her newborn natural child, he/she must apply for coverage either: (1) within the first 60 days after the birth of his/her natural child and pay the required premium; or (2) within one year after the birth of his/her natural child and pay all required past-due premiums and in addition pay interest on such premium payments at a rate of 5.5% per year. If that child is eligible for coverage under this policy, the effective date for such coverage will be the date of that child's birth. If a covered policyholder fails to do either (1) or (2), his/her newborn natural child will only be eligible if that child meets HIRSP eligibility requirements as outlined in s. 149.12, Wisconsin Statutes, as amended.

## Section V. Definitions

In this policy, the following words shall mean:

**Alcoholism:** a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within a classification category or code 303 - Alcohol Dependence Syndrome, 304 - Drug Dependence, and 305 - Nondependent abuse of drugs and 291 - Alcohol-induced Mental Disorders or 292 - Drug-Induced Mental Disorders.

**Allowed Amount:** the amount that HIRSP would pay for covered services if the following did not apply: HIRSP medical coinsurance, HIRSP medical deductible, and HIRSP drug copayment. The provider contribution is calculated off the allowed amount.

**Calendar Year:** the period that starts with your effective date of coverage under this policy and ends on December 31st of such year. Each following calendar year shall start on January 1st of any year and end on December 31st of that year.

**Certified Nurse Midwife:** a person who is a registered nurse and is certified to practice as a nurse midwife by the American College of Nurse Midwives and by either the State of Wisconsin or by the state in which he/she practices.

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

**Coinsurance:** see "HIRSP medical coinsurance" and "Medicare Supplement coinsurance".

**Confinement/Confined:** the period starting with your admission on an inpatient basis (more than 24 hours) to a hospital or other licensed health care facility for treatment of an illness or injury. Confinement ends with your discharge from the same hospital or other facility. If you are transferred to another hospital or other facility for continued treatment of the same or related illness or injury, it's still just one confinement.

**Convenient Care Clinic:** a medical clinic that is located in a retail store, supermarket or pharmacy providing covered health care services by nurse practitioners, physician assistants or physicians within the scope of their respective licenses. A convenient care clinic provides health care services to treat minor illnesses and injuries, and preventive services.

**Copayment:** that portion of the charge for a covered expense which you are required to pay to the health care provider for a certain health care service covered under this policy. Copayments are a specific dollar amount.

**Cosmetic Surgery:** surgery performed to reshape normal structures of the body in order to improve either the patient's appearance or self-esteem.

**Cosmetic Treatment:** health care services used to improve either the patient's physical appearance or self-esteem.

**Covered Service:** a service whose cost is eligible for reimbursement by HIRSP under the conditions set forth in this policy. HIRSP considers the expense for a covered service as incurred on the date you receive the service.

**Creditable Coverage:** coverage under qualifying group health plans and insurance from any of the following:

- A. a group health plan.
- B. health insurance coverage.
- C. Medicare Parts A, B and D.
- D. Medicaid.
- E. TriCare, formerly the Civilian Health and Medical Plan of the Uniformed Services (CHAMPUS).
- F. Civilian Health and Medical Plan of the Veterans Administration (CHAMPVA).
- G. a medical care program of the federal Indian health service or of an American Indian tribal organization.
- H. a state health benefits risk pool.
- I. a federal employee health plan.
- J. a public health plan.
- K. a Peace Corps health plan.

**Custodial Care:** health care services given to you if: (a) you do not require the technical skills of a registered nurse at all times; (b) you need assistance for activities of daily living, including, but not limited to, dressing, bathing, eating, walking, taking medications or maintaining continence; and (c) the health care services you require are not likely to improve your physical and/or mental condition. Health care services may still be considered custodial care, as determined by HIRSP, even if: (a) you are under the care of a physician; (b) the physician prescribes health care services to support and maintain your physical and/or mental condition; or (c) health care services are being directly provided to you by a registered nurse or licensed practical nurse, a physical, occupational, or speech therapist, or a physician.

**Deductible:** see "HIRSP deductible" and "Medicare deductible".

**Department:** the State of Wisconsin Department of Health and Family Services.

**Drug Abuse:** a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within a classification category or code 303 - Alcohol Dependence Syndrome, 304 - Drug Dependence, and 305 - Nondependent abuse of drugs and 291 - Alcohol-induced Mental Disorders or 292 - Drug-Induced Mental Disorders.

**Durable Medical Equipment:** an item which can withstand repeated use and is, as determined by HIRSP: (a) primarily used to serve a medical purpose with respect to an illness or injury; (b) generally is not useful to a person in the absence of illness or injury; (c) appropriate for use in your home; (d) prescribed by a physician; and (e) medically necessary. HIRSP does not consider prosthetics and orthotics to be durable medical equipment.

**Eligible Individual:** an individual who meets all of the following:

- A. the aggregate of the individual's periods of creditable coverage is 18 months or more;
- B. the most recent period of creditable coverage was under a group health plan, government plan, or church plan;
- C. the individual does not currently have creditable coverage and is not currently eligible for a group health plan or Medicaid or the BadgerCare Plus Standard Plan, except as specifically stated in s. 149.12, as amended;
- D. the most recent creditable coverage was not terminated due to fraud, intentional misrepresentation, or failure to pay premium;
- E. the individual elected continuation coverage offered through a group health plan and exhausted the coverage.
- F. the individual has not had a break in insurance coverage greater than 63 days.

**Emergency Medical Care:** health care services provided by a health care provider to treat your medical emergency.

If you receive emergency medical care from a health care provider located outside of the state of Wisconsin who is not Medicaid-certified, HIRSP will cover those health care services up to the HIRSP allowed amount.

**Experimental or Investigative:** as determined by the HIRSP Medical Review Department, the use of any health care services for your illness or injury that, at the time it is used, meets one or more of the following:

- A. requires approval that has not been granted by the appropriate federal or other governmental agency, such as, but not limited to, the federal Food and Drug Administration (FDA); or
- B. isn't yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or
- C. is the subject of either: (1) a written investigational or research protocol; or (2) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (3) an ongoing phase I, II or III clinical trial, except as required by law; or (4) an ongoing review by an Institutional Review Board (IRB); or
- D. doesn't have either: (1) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (2) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning such treatment, service or supply and reflecting its recognition and reproducibility by non-affiliated sources the Plan Administrator determines to be authoritative.

Additional criteria that are used for determining whether a health care service is considered to be experimental or investigative and, therefore, not covered, for a particular illness or injury include, but are not limited to:

- A. the failure rate and side effects of the health care service;
- B. whether other more conventional methods of treatment have been first exhausted;
- C. whether the health care service is medically necessary for the treatment of that illness or injury;
- D. whether the health care service is universally recognized as not experimental or investigative by Medicare, Medicaid and other third party payers (including insurers and self-funded plans); or
- E. whether any documentation refers to the health care service as posing an uncertain outcome or having an unusual risk.

Investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended, and drugs which by law require a written prescription used in the treatment of cancer that may not currently have FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis, are covered under this policy, if applicable.

To question whether a particular health care service is considered experimental or investigative, please contact HIRSP Medical Affairs staff at 866-841-6572.

The determination of whether a health care service is experimental or investigative under the definition set out above and our criteria shall be made by HIRSP in its sole and absolute discretion. In any dispute arising as a result of its determination, such determination shall be upheld if the decision is based on any credible evidence. In any event, if the decision is reversed, the limit of HIRSP liability under this policy or on any other basis shall be to provide policy benefits only and neither compensatory nor punitive damages, nor attorney's fees, nor other costs of any kind shall be awarded in connection therewith or as a consequence thereof.

**Facility:** a clinic, hospital or other entity licensed to provide health care services covered under this policy.

**Health Care Provider:** any person, institution or other entity licensed by the state in which he/she or it is located to provide health care services covered by this policy to you, within the lawful scope of his/her or its license.

**Health Care Services:** treatment, services, procedures, drugs or medicines, devices, or supplies directly provided to you and covered under this policy, except to the extent that such treatment, services, procedures, drugs or medicines, devices, or supplies are limited or excluded under this policy.

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

**HIRSP:** the Health Insurance Risk-Sharing Plan.

**HIRSP Authority:** the entity charged with the administrative responsibility for HIRSP.

**HIRSP Drug Copayment:** the dollar amount for which you are responsible for drug benefits before HIRSP will consider payment for covered drugs.

**HIRSP Medical Coinsurance/HIRSP Coinsurance:** the percentage of the HIRSP allowed amount for which you are responsible for medical benefits. Wherever this policy refers to HIRSP coinsurance, it means HIRSP medical coinsurance.

**HIRSP Medical Deductible/HIRSP Deductible:** a defined amount for which you are responsible for medical benefits before HIRSP will consider payment for a covered service. Wherever this policy refers to HIRSP deductible, it means HIRSP medical deductible.

**Home Care:** health care services directly provided to you in your home under a written home care plan. The attending physician must set up the home care plan. Such plan must be approved in writing by that physician. The physician must review it at least every two months; but the review can be less frequent if the physician decides longer intervals are enough and the Plan Administrator agrees.

**Hospice Care:** health care services provided to you whose life expectancy, as certified by a physician, is six consecutive months or less, and which are provided by a licensed hospice care provider approved by HIRSP. The care must be available on an intermittent basis with on-call health care services available on a 24-hour basis. Such care shall include health care services provided to ease pain and make you as comfortable as possible.

**Hospital:** means **any** of the following places certified by Medicaid:

- A. Licensed or recognized as a general hospital.
- B. Operated for the care and treatment of resident inpatients with a laboratory and X-ray facility and a registered nurse always on duty.

- C. Recognized as a general hospital by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
- D. Certified as a hospital by Medicare.

Not included is a hospital or institution or a part of such hospital or institution that is licensed or used principally as a clinic, continued or extended care facility, skilled nursing care facility, convalescent home, rest home, nursing home, sub-acute care center, health resort, spa, or home for the aged.

**Illness:** a physical illness, alcoholism, drug abuse, or a nervous or mental disorder.

**Immediate Family:** your spouse, natural and adopted children, parents, grandparents, brothers, and sisters, and the spouses of such persons.

**Incidental:** associated services or items which are integral to the performance of another service or item, or which does not add significant time or effort to the other service or item.

**Infertility:** the physical inability to conceive after at least 12 consecutive months of unprotected sexual intercourse, and such inability is documented by a health care provider.

**Injury:** bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes. An accident caused by chewing resulting in damage to your teeth is not considered an injury.

**Licensed Skilled Nursing Facility:** a nursing facility licensed as a skilled nursing facility by the state in which it is located. The facility must be staffed, maintained and equipped to provide these skilled nursing services continuously: observation and assessment; care; restorative and activity programs. These services must be provided under professional direction and medical supervision as needed.

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

**Maternity Services:** professional services for prenatal and postnatal care. This includes: laboratory procedures; delivery of the newborn; cesarean and porro-cesarean sections; and care for miscarriages.

**Maximum Lifetime Benefit:** the maximum dollar amount of benefits you may receive from HIRSP in your lifetime. See Section VI. Maximum Lifetime Benefit for more information.

**Medicaid:** Wisconsin Medicaid, which is a joint federal/state program that pays for medical services for eligible people as provided under Subsection IV of Chapter 49, Wisconsin Statutes.

**Medical Emergency:** a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain. The condition must be severe enough to lead a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

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

**Medical Services:** professional services recognized by a physician in the treatment of illness or injury and directly provided to you. Not included are: maternity services; surgical services; anesthesia services; pathology; and radiology.

**Medical Supplies:** items which are, as determined by HIRSP: (1) used primarily to treat an illness or injury; (b) generally not useful to a person in the absence of an illness or injury; (c) the most appropriate item which can be safely provided to you and accomplish the desired end result in the most economical manner; and (d) prescribed by a physician. The item's primary function must not be for the patient's comfort or convenience.

**Medicare:** the health insurance program operated by the U.S. Department of Health and Human Services under Title 42 U.S. Code Section 1395 and Title 42 Code of Federal Regulation subchapter B.

**Medicare Coinsurance:** the percentage of the amount Medicare allows for which the Medicare beneficiary is responsible.

**Medicare Deductible:** a defined amount for which the Medicare beneficiary is responsible before Medicare will consider payment for a covered service.

**Medically Necessary:** a health care service directly provided to you by a hospital, physician, or other health care provider that is required to identify or treat your illness or injury and which is, as determined by HIRSP:

- A. consistent with your symptoms or diagnosis and treatment of your illness or injury;
- B. provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
- C. appropriate with regard to generally accepted standards of medical practice;
- D. not medically contraindicated with regard to your diagnoses, your symptoms, or other medically necessary and appropriate services being provided to you;
- E. of proven medical value or usefulness and not experimental in nature;
- F. not duplicative with respect to other services being provided to you;
- G. not solely for the convenience of the policyholder, the policyholder's immediate family, or a provider;
- H. the most appropriate supply or level of service that can safely and effectively be provided to you.

**Miscellaneous Hospital Expense:** the allowed amount for regular hospital expenses (but not room and board, nursing services, and ambulance services) HIRSP covers under this policy for treatment of an illness or injury requiring either inpatient hospitalization or outpatient health care services at a hospital. For outpatient health care services, this includes the allowed amount for use of the hospital's emergency room and for emergency medical care provided to you at the hospital. Miscellaneous hospital expenses include take-home drugs.

**Morbid Obesity/Morbidly Obese:** when your Body Mass Index (BMI): (a) is 35 or above for policyholders age 19 and over; or (b) falls above the 85th percentile on the growth chart if the policyholder is less than 19 years old. Body Mass Index is defined as your weight in kilograms divided by the square of your height in meters. A physician must define Morbid Obesity utilizing the method stated in this definition.

**Nervous or Mental Disorders:** a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within one of the following classification categories or codes: 295 - Schizophrenic Disorders; 296 - Episodic Mood Disorders; 297 - Delusional Disorders; 298 - Other Nonorganic Psychoses; 300 - Anxiety, Dissociative and Somatoform Disorders; 301 - Personality Disorders; 302 - Sexual and Gender Identity Disorders; 306 - Physiological Malfunction Arising From Mental Factors; 307 - Special Symptoms or Syndromes, Not Elsewhere Classified; 308 - Acute Reaction to Stress; 309 - Adjustment Reaction; 311 - Depressive Disorder, Not Elsewhere Classified; 312 - Disturbance of Conduct, Not Elsewhere Classified; 313 - Overanxious Disorder; and 314 - Hyperkinetic Syndrome of Childhood.

**Nurse Practitioner:** an individual who is licensed as a registered nurse under Chapter 441, Wisconsin Statutes, as amended, or the laws and regulations of another state and who satisfies any of the following: (a) is certified as a primary care nurse practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; (b) holds a master's degree in nursing from an accredited school of nursing; (c) prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least four months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program; or (d) has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery

of primary care but that does not meet the requirements of (c) above, and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

**Outpatient Treatment Facility:** means a Medicaid-certified provider:

- A. Licensed or approved by the Department.
- B. Whose outpatient services meet the Department's standards.
- C. That provides the following outpatient services to prevent and treat disabling conditions:
  - 1. Comprehensive diagnostic and evaluation services.
  - 2. Outpatient care and treatment, precare, aftercare, emergency care, rehabilitation, and supportive transitional services.
  - 3. Professional consultation.

Examples of outpatient treatment facilities include, but are not limited to, psychiatric facilities, ambulatory surgical centers, urgent care centers, rehabilitation centers, or hospital outpatient surgical centers.

**Physical Illness:** a disturbance in a function, structure or system of the human body which causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of the health state of the function, structure or system of the human body. Physical illness includes pregnancy and complications of pregnancy. Physical illness does not include alcoholism, drug abuse, or a nervous or mental disorder.

**Physician:** a Medicaid-certified provider licensed to practice medicine and surgery, including a graduate of an osteopathic college who holds an unlimited license to practice medicine and surgery.

**Plan Administrator:** the entity acting as the health claim administrator under the terms of an Administrative Services Agreement with HIRSP.

**Policy Effective Date:** the date the HIRSP policy takes effect, in accordance with the terms in this policy.

**Policy Renewal Date:** the day after the last day of your coverage period under HIRSP.

**Policyholder:** a person covered by HIRSP.

**Professional Services:** services directly provided to you by a physician of your choice to treat your illness or injury. Such services also include services provided by a certified registered nurse anesthetist, registered or licensed practical nurse, laboratory/x-ray technician and physician assistant, provided such person is lawfully employed by the supervising physician or the facility where the service is provided and he/she provides an integral part of the supervising physician's professional services while the physician is present in the facility where the service is provided. With respect to such services provided by a registered or licensed practical nurse, laboratory/x-ray technician and physician assistant, such services must be billed by the supervising physician or the facility where the service is provided. Such services also include services provided by a physician assistant or nurse practitioner when such services are provided at a convenient care clinic.

**Provider Contribution:** the amount that providers contribute to the HIRSP program, in the form of reduced reimbursement from approximate commercial reimbursement, in order to fund their required 20% of program costs plus 50% of premium and deductible subsidies as defined by statute.

**Reasonable:** means that a health care service meets all the following conditions:

- A. provides therapeutic benefits in an economic manner;
- B. does not serve the same purpose as a health care service already available to you.

**Reconstructive Surgery:** surgery performed on abnormal structures of the body, caused by congenital defects, development abnormalities, trauma, infection, tumors or disease.

**Resident:** a person who has been legally domiciled in the State of Wisconsin for a period of at least three months or, with respect to an eligible individual, an individual who resides in this state. Legal domicile is established by living in this state and obtaining a Wisconsin driver's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return.

A child is legally domiciled in this state if the child lives in this state and at least one of the child's parents or a child's legal guardian is legally domiciled in this state.

A person with a developmental disability or another disability that prevents the person from obtaining a Wisconsin driver's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return is legally domiciled in this state by living in this state.

**Service:** a service, treatment, procedure, therapy, drug, device, or supply that you receive from a health care provider. It may or may not be a covered service.

**Skilled Nursing Care:** professional nursing services that meet all of the following conditions:

- A. furnished under a Medicaid-certified physician's orders;
- B. requires the skills of a Medicaid-certified registered nurse or licensed practical nurse to be safely and effectively performed;
- C. provided either directly by or under the supervision of the registered nurse or licensed practical nurse.

**Sound Natural Teeth:** teeth that: (a) are organic and formed by the natural development of the human body; (b) are not manufactured; (c) have not been extensively restored; (d) have not become extensively decayed or involved in periodontal disease; and (e) are not more susceptible to injury than whole natural teeth.

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

**Supportive Care:** supportive care is health care services provided to a policyholder whose recovery has slowed or ceased entirely, and only minimal rehabilitative gains can be demonstrated with continuation of such health care services.

**Surgical Services:** an operative procedure performed by a physician and that is recognized by HIRSP for the treatment of an illness or injury. Such services include preoperative and postoperative care. Such services shall not include oral surgical services and maternity services.

**Treatment:** management and care directly provided to you by a physician or other health care provider for the diagnosis, remedy, therapy, combating, or the combination thereof, of an illness or injury, as determined by us.

**You, Your:** the policyholder.

## **Section VI. Maximum Lifetime Benefit**

The maximum lifetime benefit is shown in Section 3. of the Schedule of Benefits. The lifetime maximum benefit limit applies to all covered services incurred during your lifetime while you are covered under this policy. No benefits are payable for expenses incurred for health care services directly provided to you either before your effective date of coverage under this policy or after your coverage has terminated under this policy. In no event will HIRSP pay more than the lifetime maximum benefit limit shown above.

## **Section VII. Pre-existing Injury or Illness Provisions**

The benefits of this policy will not be payable for any health care services related to a pre-existing injury or illness during the six months following the policy effective date. Pre-existing injury or illness means a condition, whether physical or mental, regardless of the cause of the condition, which was diagnosed or for which medical advice, care, or treatment was recommended or received during the six months immediately preceding the policy effective date. This provision does not apply if you are an eligible individual.

This provision will also not apply to those individuals who apply for coverage under this policy within 45 days of losing their coverage under: (a) Medicaid; (b) BadgerCare Plus; (c) Medicare; or (d) a state health benefits risk pool, provided the individual was covered under that risk pool for at least 12 months. These individuals must qualify for coverage under this policy as medically uninsurable and meet all eligibility criteria associated with that designation.

## **Section VIII. Deductible, Coinsurance and Out-of-Pocket Limits and Reimbursement**

### **A. HIRSP Medical Deductible, HIRSP Medical Coinsurance, and HIRSP Medical Out-of-Pocket Limits**

#### **1. HIRSP Medical Deductible.**

The HIRSP medical deductible amount is shown in Section 1. a. of the Schedule of Benefits. The annual deductible amount does not apply to prescription drugs and diabetic supplies.

The HIRSP medical deductible amount applies each calendar year. The allowed amount for covered expenses for health care services directly provided to you must add up to the appropriate deductible amount before benefits are payable for other allowed amounts for covered expenses. No benefits are payable for the allowed amount used to satisfy your deductible amount. You are responsible for paying the allowed amount used to satisfy the appropriate deductible amount.

#### **2. HIRSP Medical Coinsurance Amount**

After the appropriate HIRSP deductible amount stated in the Schedule of Benefits is satisfied, benefits are payable at the coinsurance percentage stated in Section 1. b. of the Schedule of Benefits of the allowed amount, subject to the annual out-of-pocket limit shown in Section 3. of the Schedule of Benefits, subject to all the terms, conditions and provisions of this policy.

#### **3. Medical Out-of-Pocket Limits.**

**a. Individual Out-of-Pocket Limit.** The annual out-of-pocket limit for covered expenses for health care services directly provided to you is shown in Section 1. c. (1) of the Schedule of Benefits.

This total is made up of the HIRSP medical deductible amount and HIRSP medical coinsurance amount which you pay for covered expenses for health care services directly provided to you in one calendar year.

**b. Family Out-of-Pocket Limit.** The annual out-of-pocket limit for covered expenses for health care services directly provided to a family is shown in Section 1. c. (2) of the Schedule of Benefits. Family means two or more of the following persons, or any combination thereof, who are insured under HIRSP: either or both spouses and all dependent children of either spouse. This total is made up of all amounts applied within a calendar year to HIRSP medical deductible and HIRSP medical coinsurance for a family under the same plan.

After the applicable annual out-of-pocket limit is reached, benefits are payable at 100% of the allowed amount for covered services, unless specifically stated otherwise in this policy, incurred by you during the remainder of the calendar year, subject to the lifetime maximum benefit limit and all other terms, conditions and provisions of this policy.

**B. HIRSP Drug Deductible and Copayment Amounts**

**1. HIRSP Drug Deductible.**

There is no HIRSP drug deductible. You do not pay any deductible, including the HIRSP medical deductible for prescription drugs and diabetic supplies.

**2. HIRSP Drug Copayment Amounts.**

When you incur expenses for the covered services indicated under Section IX. B. 4. due to an injury or illness, we will pay 100% of the allowed amount, subject to the copayment amounts shown in Section 2. a. and b. of the Schedule of Benefits for each fill or refill for each prescription.

**3. Drug Out-of-Pocket Limits.**

The annual out-of-pocket limit for covered expenses for prescription legend drugs covered is based upon your household income and is shown in Section 2. c. of the Schedule of Benefits. The annual out-of-pocket limit is made up of the HIRSP drug copayment amounts stated above which you pay for covered expenses for covered drugs in one calendar year.

After the applicable annual out-of-pocket limit is reached, benefits are payable at 100% of the allowed amount for covered drugs during the remainder of the calendar year, subject to the lifetime maximum benefit limit and all other terms, conditions and provisions of this policy.

**C. Reimbursement**

**1. General Reimbursement.**

HIRSP uses several methods for reimbursing claims, such as:

- a. Outpatient hospital claims by a percentage of allowed amount. Some services are not included in these rates and need to be billed separately on the approved claim form.
- b. Inpatient hospital claims by rate per stay based on diagnosis-related group. Some services are not included in these rates and need to be billed separately on the approved claim form.
- c. Skilled nursing care facility claims by rate per day. Some services are not included in these rates and need to be billed separately on the approved claim form.
- d. Most other services by a specific rate per service.

**2. Medicare Deductible and Coinsurance.**

For a policyholder who is covered under Medicare, HIRSP will pay Medicare deductible and Medicare coinsurance as long as the service is a HIRSP covered service. HIRSP's covered services, which are listed in this policy, may not necessarily be the same as a Medicare-covered benefit.

If charges for a covered health care service are denied by Medicare solely because the policyholder did not receive the health care service from a Medicare-certified provider, then HIRSP's reimbursement will not exceed 20% of the HIRSP allowed amount.

For all services not covered by Medicare solely because that service is not a Medicare-covered benefit, benefits will be payable under this policy subject to applicable deductible and coinsurance provisions of this policy and all other conditions and provisions of this policy.

**3. Assignment of Benefits.**

HIRSP will issue payment either to the Medicaid-certified provider or to you according to information provided on the claim form. If the claim form does not contain instructions that indicate who should receive payment, HIRSP, at its option, will pay you or the provider of the services.

Any benefits payable to you that are unpaid at the time of your death will be paid to your beneficiary.

If any benefits are payable to your estate or to anyone showing proof of primary beneficial interest, HIRSP may pay up to \$1,000.00 to anyone whom it finds entitled to the payment. Payment made in good faith shall fully discharge HIRSP to the extent of the payment.

**4. Payment in Full.**

Medicaid-certified health care providers are prohibited under law by Section 149.142(2m), Wisconsin Statutes, from billing you for the difference between the amount billed for a covered service and the amount paid by HIRSP, except for HIRSP medical coinsurance, HIRSP drug copayment, and HIRSP medical deductible. If a policyholder receives services from a Medicaid-certified health care provider, he/she will only be responsible for the HIRSP medical coinsurance and HIRSP medical deductible.

## **Section IX. Benefits**

**A. Payment of Benefits**

**1. Health Care Services Provided In Wisconsin.**

If you receive health care services described in this section from a health care provider in Wisconsin, that health care provider must be a Wisconsin Medicaid-certified health care provider. HIRSP will pay benefits up to the HIRSP allowed amount. You are responsible for any applicable deductible and coinsurance amounts.

**2. Health Care Services Provided Outside of Wisconsin.**

If you receive health care services described in this section from a health care provider outside of Wisconsin who is not Wisconsin Medicaid-certified, HIRSP will pay benefits for those health care services up to the HIRSP allowed amount. You are responsible for any amounts billed over the HIRSP allowed amount. The billed amount you are responsible for may be as much as, if not more than, 40% of the provider's charge for those health care services. Also, you are responsible for any applicable deductible and coinsurance amounts.

**B. Covered Services**

Subject to the HIRSP deductible amount shown in Section VIII., benefits are payable as stated in this section for the allowed amount for covered services you incur in connection with a covered illness or injury, subject to all the provisions of this policy. Covered services must be incurred while you are covered under this policy. The HIRSP deductible must be satisfied for the calendar year in which the covered services are incurred before benefits are payable, unless specifically stated otherwise in this policy.

Benefits are payable for the allowed amount for covered services as described in this section. You are also solely responsible to pay for all health care services or other services not covered under this policy.

All health care services must be medically necessary. All health care services must be ordered by a physician because of a covered illness or injury. If the health care service is not listed in this section, that health care service is not covered and benefits are not payable under this policy. Benefits are not payable

for maintenance care, custodial care, supportive care, or any health care service to which an exclusion applies. Please see Section XI. General Exclusions.

Benefits are payable for the allowed amount for the following covered services:

**1. Alcoholism, Drug Abuse and Nervous or Mental Disorders**

**a. Definitions.** The following definitions apply to this paragraph 1. only:

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

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

**Hospital:** (1) a hospital licensed under Section 50.35, Wisconsin Statutes, as amended; (2) an approved private treatment facility as defined in Section 51.45 (2) (b), Wisconsin Statutes, as amended; or (3) an approved public treatment facility as defined in Section 51.45 (2)(c), Wisconsin Statutes, as amended.

**Inpatient Hospital Services:** (1) services for the treatment of nervous or mental disorders, alcoholism or drug abuse that are directly provided to a member who is a bed patient in the hospital; and (2) services for the treatment of alcoholism or drug abuse that are directly provided to a member in a facility with a program certified by the Department under Section HFS 61.63, Wis. Adm. Code, as amended. However this definition shall not include those inpatient hospital services for detoxification of drug addiction or alcohol dependency. Please see paragraph "20. Hospital Services."

**Outpatient Services:** nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse problems directly provided to you and, if for the purpose of enhancing your treatment, provided to a collateral by any of the following: (1) a program in an outpatient treatment facility, if both the program and facility are approved by the Department and established and maintained according to rules promulgated under Section 51.42 (7)(b), Wisconsin Statutes, as amended; (2) a licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office; (3) a psychologist licensed or certified by the state in which he/she is located; or (4) a health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse.

**Residential Treatment Programs:** therapeutic programs for treatment of nervous or mental disorders and alcohol and drug dependent members, including therapeutic communities and transitional facilities.

**Transitional Treatment Arrangements:** services for the treatment of nervous or mental disorders, alcoholism or drug abuse that are directly provided to you in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services, if both the program and the facility are approved by the Department as defined in the Section Ins 3.37, Wis. Adm. Code, as amended. Such transitional treatment is limited to: (1) mental health services for adults in a day treatment program offered by a provider certified by the Department under Section HFS 61.75, Wis. Adm. Code, as amended; (2) mental health services for children and adolescents in a day treatment program offered by a provider certified by the Department under Section HFS 40.04, Wis. Adm. Code, as amended; (3) services for persons with chronic mental illness provided through a community support program certified by the Department under Section HFS 63.03, Wis. Adm. Code, as amended; (4) residential treatment programs for

treatment of nervous or mental disorders and for alcohol and drug dependent persons, certified by the Department under Section HFS 75.14 (1) and (2), Wis. Adm. Code, as amended; (5) services for alcoholism and other drug problems provided in a day treatment program certified by the Department under Section HFS 75.12 (1) and (2), Wis. Adm. Code, as amended; (6) intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine; (7) out-of-state services and programs that are substantially similar to (1), (2), (3), (4) and (5) if the provider is in compliance with similar requirements of the state in which the health care provider is located; and (8) coordinated emergency mental health services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services are provided by a program certified by the Department under Section HFS 34.03 and provided in accordance with subch. III HFS 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other providers for stabilization. Certified emergency mental health service plans shall provide timely notice to third-party payers to facilitate coordination of services for persons who are experiencing or are in a situation likely to turn into a mental health crisis.

The criteria that the Plan Administrator uses to evaluate a transitional treatment program or service to determine whether it is medically necessary and covered under this policy include, but are not limited to, whether:

- (1) the program is certified by the Department;
- (2) the program meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;
- (3) the specific diagnosis is consistent with the symptoms;
- (4) the treatment is standard medical practice and appropriate for the specific diagnosis;
- (5) the treatment plan is focused for the specific diagnosis;
- (6) the multidisciplinary team running the program is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider's program is located or the service is provided;

The Plan Administrator will need the following information from the health care provider to help us determine the medical necessity of such program or service:

- (1) a summary of the development of your illness and previous treatment;
- (2) a well-defined treatment plan listing treatment objections, goals and duration of the care provided under the transitional treatment arrangement program; and
- (3) a list of credentials for the staff who participated in the transitional treatment arrangement program or service, unless the program or service is certified by the Department.

**b. Benefits.** Benefits are payable as stated below, unless applicable state or federal mandated benefits are greater. In that case, the applicable state or federal mandated benefits shall apply.

- (1) **Inpatient Hospital Services.** Each calendar year, benefits are payable for covered expenses you incur in that calendar year for inpatient hospital services and are limited to 30 days.

- (2) **Outpatient Services.** Each calendar year, benefits are payable for covered expenses you incur in that calendar year for outpatient services.
- (3) **Transitional Treatment Arrangements.** Each calendar year, benefits are payable for covered expenses you incur in that calendar year for transitional treatment arrangements. This benefit is in addition to outpatient hospital benefits for alcoholism, drug abuse, and nervous or mental disorders.
- (4) **Prescription Drugs.** Each calendar year, benefits are payable for covered expenses you incur in that calendar year for prescription drugs provided by a health care provider: (a) licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse; and (b) licensed to dispense prescription drugs. Prescription drugs that can be self-administered and/or can be provided to you by a pharmacy are not covered under this paragraph.
- (5) **Nutritional Counseling.** Benefits are payable for covered expenses for nutritional counseling for a policyholder who is diagnosed with an eating disorder such as bulimia or anorexia nervosa. Such counseling must be provided by a dietician or nutritionist licensed in the state where the counseling is provided to the member.

Benefits payable under paragraph b. (2) and b. (3) are covered up to a combined maximum of 50 visits per calendar year. Benefits are payable for additional visits only if prior approval is received from the Plan Administrator. If you do not receive the Plan Administrator's prior approval in accordance with Section IV. E., benefits for such additional visits are not payable under this policy and such additional visits are not covered. Such additional visits shall not exceed 50 visits for the remainder of the calendar year.

If you are receiving methadone treatment, each time you are charged administration expenses for dispensing of methadone will count as one visit. However, these visits will not be applied to the visit limitations shown above. HIRSP recommends you receive the Administrator's prior approval for methadone treatment.

## 2. **Alternate Care.**

Sometimes your attending physician may advise you to consider an alternative course of treatment or confinement for a covered illness or injury which differs from your current course of treatment or confinement for that covered illness or injury and includes health care services not covered under this policy. Your attending physician should contact the Plan Administrator and discuss the proposed alternate care. The Plan Administrator, at its option, will consider paying benefits under this policy for charges for such health care services as long as such health care services are medically necessary to treat your illness or injury. Payment of benefits, if any, shall be made as determined by the Plan Administrator, at its option. The Plan Administrator may consider an alternative care plan if it appears that:

- a. the recommended alternative course of treatment or confinement offers a medical therapeutic value at least equal to the current treatment or confinement;
- b. the current course of treatment or confinement may be changed without jeopardizing your health; and
- c. the allowed amount incurred for health care services to be provided under the alternative course of treatment or confinement to its end will be less than those allowed amounts for health care services to be provided under the current course of treatment or confinement to its end.

The alternative care decision, if any, will be made by the Plan Administrator on a case by case basis and does not set precedent for future claims.

Any alternative care decision must be approved by the Plan Administrator, you and the attending physician before your alternative course of treatment or confinement begins. Any additional treatment or confinement beyond the agreed to alternative course of treatment or confinement must be reviewed and reconsidered by the Plan Administrator and approved by the Plan Administrator, you and the attending physician.

The Plan Administrator will send a letter to you and your attending physician. This letter will provide:

- a. the alternative course of treatment or confinement;
- b. the projected costs for such treatment or confinement; and
- c. the benefits payable for the allowed amount incurred for such course of treatment or confinement.

The benefits payable by the Plan Administrator will first be paid as provided under this policy. In the event that the alternative course of treatment or confinement includes health care services not covered under this policy, the Plan Administrator, at its option, will consider paying benefits under this policy for charges for such health care services as long as such health care services are medically necessary to treat you. Payment of benefits, if any, shall be made as determined by the Plan Administrator, at its option.

### **3. Ambulance Services.**

Ambulance services are ground and air provided by a licensed professional ambulance service using its licensed and/or certified vehicle, helicopter, or plane which is designed, equipped, and used to transport you when you are sick or injured and which is staffed by emergency medical technicians, paramedics, or other certified medical professionals:

- a. From your home, scene of an accident or medical emergency to a hospital;
- b. Between hospitals;
- c. Between a hospital and skilled nursing facility; or
- d. From a hospital or skilled nursing facility to your home.

Ambulance services include emergency medical care directly provided to you during your ambulance transport and included within the fees billed by the licensed professional ambulance service for its ambulance services. The emergency medical care for which fees are billed separately by the licensed professional ambulance service from the fees billed for the ambulance service shall be payable as stated elsewhere in this policy.

Ambulance transports must be made to the closest local facility that can provide health care services appropriate for your illness or injury, as determined by the Plan Administrator. If none of these facilities are in your local area, you are covered for transports to the closest facility outside your local area. Benefits are not payable for ambulance services:

- a. When another type of transportation can be used without endangering your health;
- b. For any transportation for the personal convenience of the policyholder, family, or physician;
- c. For any transportation undertaken to secure treatment by a personal physician or by a physician or institution of greater renown or greater specialization is not covered; and
- d. For any transportation provided by anyone other than a licensed professional ambulance service.

Our prior approval is recommended for non-emergency licensed professional ambulance services to transport you from a hospital or other health care facility to another hospital or health care facility.

**4. Autism Services.**

**a. Definitions.** The following definitions apply to this paragraph 4. only:

**Autism Spectrum Disorder:** any of the following: (1) autism disorder; (2) Asperger's syndrome; or (3) pervasive developmental disorder not otherwise specified.

**Behavioral:** interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

**Department:** the Wisconsin Department of Health Services.

**Evidence-based:** therapy that is based upon medical and scientific evidence and is determined to be an efficacious treatment or strategy.

**Efficacious Treatment or Efficacious Strategy:** treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive-level services; or to improve a policyholder with autism spectrum disorder's condition.

**Intensive-level Services:** evidenced-based behavioral therapies that are directly based on, and related to, a policyholder's therapeutic goals and skills as prescribed by a physician familiar with the policyholder.

**Nonintensive-level Services:** evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with 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.

**Provider:** a state-licensed psychiatrist, psychologist, or a social worker certified or licensed to practice psychotherapy.

**Qualified Paraprofessional:** an individual working under the active supervision of a qualified supervising provider and who complies with all of the following:

- (1) attains at least 18 years of age;
- (2) obtains a high school diploma;
- (3) completes a criminal background check;
- (4) obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid;
- (5) obtains at least 10 hours of training in the use of behavioral evidence-based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present;
- (6) receives regular, scheduled oversight by a qualified provider in implementing the treatment plan for the policyholder.

**Qualified Professional:** an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and who has completed at least 2,080 hours including all of the following:

- (1) 1,500 hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models;
- (2) supervised experience with all of the following:
  - (a) working with families as part of a treatment team and ensuring treatment compliance;
  - (b) treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
  - (c) treating individuals with autism spectrum disorders with a variety of behavioral challenges;
  - (d) treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and
- (3) academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

**Qualified Provider:** an individual acting within the scope of a currently valid state-issued license for psychiatry or psychology or a social worker licensed or certified to practice psychotherapy and who has completed at least 2080 hours that includes all of the following:

- (1) 1,500 hours supervised training involving direct 1:1 work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models;
- (2) supervised experience with all of the following:
  - (a) working with families as the primary provider and ensuring treatment compliance;
  - (b) treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
  - (c) treating individuals with autism spectrum disorders with a variety of behavioral challenges;
  - (d) treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and
  - (e) designing and implementing progressive treatment programs for individuals with autism spectrum disorders; and
- (3) academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

**Qualified Supervising Provider:** a qualified provider that is a currently valid state-licensed psychiatrist, psychologist or a social worker licensed or certified as a psychotherapist and he/she has completed at least 4,160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

**Qualified Therapist:** a speech-language pathologist or occupational therapist acting within the scope of a currently valid state issued license and who has completed at least 1,200 hours of training including all of the following:

- (1) 750 hours supervised training involving direct 1:1 work with individuals including pediatric individuals or with individuals with autism spectrum disorders using evidence-based, efficacious therapy models;
- (2) supervised experience with all of the following:
  - (a) working with families as the direct speech or occupational therapist and ensuring treatment compliance;
  - (b) treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
  - (c) treating individuals with autism spectrum disorders with a variety of behavioral challenges;
  - (d) treating individuals with autism spectrum disorders who have shown improvement to the average range in language ability and adaptive and social interaction skills.

**Therapy:** services, treatments and strategies prescribed by a treating physician and provided by a qualified provider to improve the policyholder's condition or to achieve social, cognitive, communicative, self-care or behavioral goals that are clearly defined within the policyholder's treatment plan.

**Therapist:** a state-licensed speech-language pathologist or occupational therapist acting within the scope of the currently valid license.

**Waiver Program:** services provided by the department through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare & Medicaid Services.

- b. **Benefits.** Benefits are payable for charges for covered expenses as described in this paragraph 4. for policyholders who have a verified diagnosis of autism spectrum disorder, as determined by the Plan Administrator. Services must be prescribed by a physician and provided by any of the following who are qualified to provide intensive level services or nonintensive-level services: (1) a qualified provider; (2) a qualified paraprofessional under the supervision of a qualified supervising provider; (3) a qualified professional; or (4) a qualified therapist

The benefits under this paragraph 4. do not include benefits for durable medical equipment and prescription legend drugs. For coverage of durable medical equipment and prescription legend drugs, see paragraph "14. Durable Medical Equipment" and paragraph "13. Drug Benefits".

Benefits are payable for the following:

- (1) **Intensive-Level Services.** Benefits are payable for charges for intensive-level services, the majority of which shall be provided to the policyholder when the parent or legal guardian is present and engaged and all of the prescribed intensive-level services must meet all of the following requirements:
  - (a) be 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 participant be present and engaged in the intervention. The Plan Administrator may request and review the policyholder's treatment plan and the summary of progress on a periodic basis;

- (b) implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals;
- (c) provided in an environment most conducive to achieving the goals of the policyholder's treatment plan;
- (d) include training and consultation, participation in team meetings and active involvement of the policyholder's family and treatment team for implementation of the therapeutic goals developed by the team;
- (e) begin after a policyholder is two years of age and before the policyholder is nine years of age; and
- (f) the policyholder is directly observed by the qualified provider at least once every two months.

Benefits are payable for up to four years of intensive-level services during a policyholder's lifetime, subject to a maximum benefit limit of \$50,000 per policyholder per calendar year. The four-year lifetime maximum will be reduced by any previous length of time during which the policyholder received intensive-level services.

- (2) **Nonintensive-Level Services.** Benefits are payable for charges for nonintensive-level therapy services that are evidenced-based provided to a policyholder by a qualified provider, qualified professional, qualified therapist or qualified paraprofessional in either of the following conditions:

- (a) after the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level services treatment; or
- (b) to a policyholder who has not and will not receive intensive-level services but for whom nonintensive-level services will improve the policyholder's condition.

All nonintensive level services must meet all of the following requirements:

- (a) be 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 policyholder be present and engaged in the intervention. The Plan Administrator may request and review the policyholder's treatment plan and the summary of progress on a periodic basis;
- (b) implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals;
- (c) provided in an environment most conducive to achieving the goals of the policyholder's treatment plan;

- (d) includes training and consultation, participation in team meetings and active involvement of the policyholder's family and treatment team for implementation of the therapeutic goals developed by the team;
- (e) provides supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

Benefits are payable up to a benefit maximum of \$25,000 per policyholder per calendar year for nonintensive-level services.

- c. **Transition from Intensive-Level Services to Nonintensive-Level Services.** The Plan Administrator shall provide a policyholder, or his/her authorized representative, of the change in a policyholder's level of treatment. The notice shall indicate the reason for the transition that may include any of the following:

- (1) the policyholder has received four cumulative years of intensive-level services;
- (2) the policyholder no longer requires intensive-level services as supported by documentation from a qualified provider or supervising provider; or
- (3) the policyholder no longer receives evidence-based therapy for at least 20 hours per week over a six month period of time.

The policyholder, or his/her representative, should notify the Plan Administrator if he/she is unable to receive intensive-level services for an extended period of time. The notification must indicate the specific reason or reasons the policyholder or the policyholder's family or care giver are unable to comply with an intensive-level service treatment plan. Reasons for requesting intensive-level services be interrupted for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason acceptable to the Plan Administrator.

The Plan Administrator will not deny intensive-level services to a policyholder for failing to maintain at least 20 hours per week of evidence based behavioral therapy over a six-month period when: (1) the policyholder notifies the Plan Administrator as stated above; or (2) the policyholder, or his/her authorized representative, can document that the policyholder failed to maintain at least 20 hours per week of evidence-based behavioral therapy due to waiting for waiver program services.

- d. **Exclusions.** This paragraph 4. is not subject to the exclusions in Section XI. General Exclusions. This paragraph 4. is subject to the following exclusions. This policy provides no benefits for:

- (1) acupuncture;
- (2) animal-based therapy including hippotherapy;
- (3) auditory integration training;
- (4) chelation therapy;
- (5) child care fees;
- (6) cranial sacral therapy;
- (7) hyperbaric oxygen therapy;
- (8) custodial or respite care;
- (9) special diets or supplements;
- (10) travel time by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals;

- (11) therapy, treatment or services when provided to a policyholder who is residing in a residential treatment center, inpatient treatment or day treatment facility;
- (12) costs for the facility or location or for the use of a facility or location when treatment, therapy or services are provided outside of a policyholder's home;
- (13) claims that have been determined by the Plan Administrator to be fraudulent; and
- (14) treatment provided by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessionals for treatment provided to their own children.

**5. Biofeedback.**

Biofeedback for policyholders at least 18 years old, only when all of the following conditions are met:

- a. provided by a Medicaid-certified physician, physical therapist, or occupational therapist; and
- b. Used for treatment of muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness and urinary incontinence.

**6. Blood.**

Blood processing, including, but not limited to, the allowed amount for collecting, testing, fractioning, and distributing blood.

**7. Breast Reconstruction.**

Breast reconstruction of the affected tissue incident to a mastectomy. Benefits are also payable for the allowed amount for: surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prostheses; and physical complications for all stages of mastectomy, including lymphedemas.

**8. Cardiac Rehabilitation.**

Outpatient cardiac rehabilitation services. Services must be directly provided to you in a facility with a facility-approved cardiac rehabilitation program. This coverage applies only to a policyholder with a recent history of: (a) a heart attack (myocardial infarction); (b) coronary bypass surgery; (c) onset of angina pectoris; (d) onset of unstable angina; (e) onset of decubital angina; (f) heart valve surgery; (g) percutaneous transluminal angioplasty or (h) another condition for which we determine cardiac rehabilitation as being appropriate for treating your medical condition. Benefits are payable for charges for up to 48 supervised and monitored exercise sessions per covered illness starting with the first session in the outpatient exercise program. Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under this policy.

**9. Chiropractic Services.**

Chiropractic services when provided within the scope of the health care provider's license.

**10. Contraceptives for Birth Control.**

Benefits are payable for charges for devices or medications used as contraceptives which require a prescription or intervention by a physician or other licensed health care provider, including related health care services. Examples include:

- a. Intrauterine devices (IUD);
- b. Subdermal contraceptive implants (Norplant);

- c. Diaphragms;
- d. Injections of medication for birth control.

Benefits for oral contraceptives, contraceptive patch and NuvaRing are covered under the prescription legend drug benefit of this policy, if applicable.

Benefits are not payable for contraceptive devices or supplies which can be obtained without intervention by a physician or other licensed health care provider including, but not limited to, condoms and contraceptive foam or gel.

#### **11. Dental Related Services.**

- a. Hospital or ambulatory surgery center charges and anesthetics provided for dental care for a policyholder if he or she meets any of the conditions below:
  - (1) The policyholder is under the age of five.
  - (2) The policyholder has a chronic disability that is attributable to a mental and/or a physical impairment that results in substantial functional limitation in an area or major life activity, and the disability is likely to continue indefinitely.
  - (3) The policyholder has a medical condition that requires hospitalization or general anesthesia for dental care.
- b. Dental repair of your sound natural teeth due to an injury, provided treatment begins within six months of the injury.

The Plan Administrator's prior approval is required for any non-emergency dental repair. If you do not receive the Plan Administrator's prior approval in accordance with subsection "E. Prior Approval of Health Care Services," benefits for such non-emergency dental repair will not be payable under this policy.
- c. Oral surgery for excision of partially or completely unerupted, impacted teeth and oral surgery with respect to the gums and other tissues of the mouth when not performed in connection with the extraction or repair of teeth.
- d. Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease;
- e. Sealants on existing teeth to prepare the jaw for chemotherapy treatment of neoplastic disease.

#### **12. Diabetes Treatment.**

If you incur expenses because of diabetes, HIRSP will pay the following:

- a. The installation, use, or purchase of an insulin infusion pump after the policyholder has used it for 30 days.
- b. Other durable medical equipment or disposable medical supplies for the treatment of diabetes, excluding insulin and disposable diabetic supplies covered elsewhere under this policy. HIRSP covers some supplies only for diabetics. For coverage of insulin and certain disposable diabetic supplies, see paragraph "13. Drug Benefits".
- c. Diabetic shoes and orthotics, when such shoes and orthotics are medically necessary.
- d. Expenses incurred for a diabetic outpatient self-management education program that meets the following criteria:
  - (1) Is taught or supervised by a Medicaid-certified physician, a registered nurse, a pharmacist, or other provider.

- (2) Teaches diabetic patients and their immediate families the diabetic disease process and the daily diabetic therapy to avoid frequent hospital confinements and complications.
  - (3) Meets any standards by which the State of Wisconsin certifies or approves such programs.
  - (4) Does not include a program that is mainly for the purpose of weight reduction.
- e. One routine eye exam per calendar year.

**13. Drug Benefits.**

- a **Definitions.** The following definitions apply only to this paragraph 13.:

**Brand-Name Drug/Brand-Name Drugs:** prescription legend drugs on the formulary sold by the pharmaceutical company or other legal entity holding the original United States patent for that prescription legend drug. For purposes of this policy, brand-name drugs are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic drug classifications.

**Formulary:** a list of prescription drugs, established by a committee of physicians and pharmacists, which are determined to be medically necessary and appropriate. If you or a health care provider requests a non-formulary drug, the PBM may require that it be prior authorized before it will be covered under the prescription drug benefit. The formulary may be revised as deemed necessary by the PBM.

**Generic Drug/Generic Drugs:** prescription legend drugs on the formulary sold by a pharmaceutical company or other legal entity other than the one holding the original United States patent for that prescription legend drug. For purposes of this policy, generic drugs are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic drug classifications.

**Generic Equivalent:** a prescription drug that contains the same active ingredients, the same dosage form, and the same strength as its brand name drug counterpart.

**Maintenance Drugs:** covered drugs used to treat or maintain an ongoing illness including, but not limited to, high blood pressure, high cholesterol, or diabetes.

**Maintenance Medication Network Pharmacy:** pharmacies which have contracted with HIRSP to be maintenance medication network pharmacies and agree in writing to provide the services that are administered by the PBM and covered under this policy to you for maintenance drugs dispensed by the maintenance medication network either by mail or at the pharmacy. The maintenance medication network pharmacy dispenses up to a 90-day supply of maintenance drugs.

**Network Pharmacy:** Medicaid-certified pharmacy health care providers in Wisconsin and MedTrak network pharmacies located outside of Wisconsin who have agreed in writing to provide the services that are administered by the PBM and covered under this policy to you. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under this policy, are provided to you. The list of network pharmacies is available on the Internet at [www.medtrakservices.com](http://www.medtrakservices.com) or by request from MedTrak. Please note that network pharmacies may change periodically. You should check with the pharmacy to make sure it is a network pharmacy.

**PBM:** Pharmacy Benefit Manager (PBM). The Pharmacy Benefit Manager, MedTrak, is a third party administrator that is contracted with HIRSP to administer the prescription drugs under this program. MedTrak is primarily responsible for processing and paying

prescription drug claims, developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

**Prescription Drugs:** legend drugs and biologicals that are FDA approved which by law require a written prescription and are prescribed for treatment of a diagnosed illness or injury. Prescription drugs include investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended. The PBM may classify a prescription drug as not covered if it determines that the prescription drug does not add clinical value over currently available therapies.

**Prior authorization:** obtaining approval from the PBM before coverage of certain drugs would apply. Prior authorization is initiated by your physician and is done in writing.

**Self-Administered Injectables:** an injectable that can be safely self-administered by a layperson. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intraarterial) injectables or any drug administered through infusion.

**Specialty Drugs:** prescription drugs that have one or more of the following characteristics, as determined by HIRSP: (a) expensive with high medical cost potential; (b) produced through a biotechnology mechanism/process; (c) administered by injection; (d) association with complex clinical management; (e) requires close patient monitoring; and (e) distributed exclusively through a specialty pharmacy. Examples are those prescription drugs prescribed to treat HIV/AIDS, and rheumatoid arthritis, multiple sclerosis or cancer including, but not limited to: Rebif, Copaxone, Avonex, Betaseron, Humira, Enbrel, Kineret, Raptiva, Aranesp, Epogen, Procrit, Pegasys, Peg-Intron, Ribavirin, Infergen, and Intron A.

**Specialty Pharmacy:** the specialty drug network of pharmacies contracted with HIRSP to dispense specialty pharmaceuticals to policyholders. To inquire as to pharmacies that are currently participating as specialty pharmacies, please contact the HIRSP Dedicated Pharmacy Unit (MedTrak) at 1-800-757-5576.

**b. Prescription Drugs and Other Benefits Administered by the Pharmacy Benefits Manager (PBM).**

**All claims for covered prescription drugs must be submitted to your Medicare Part B or Medicare Part D carrier, if applicable, before benefits will be payable under this paragraph 13. You will be responsible for the HIRSP drug copayment for prescription legend drugs covered by Medicare.**

**You must obtain benefits at a PBM network pharmacy, or, if applicable, a maintenance medication network pharmacy or specialty pharmacy.**

If you do not show your HIRSP identification card at the pharmacy at the time you are obtaining benefits, you may need to pay the full amount and submit the following to the PBM to receive reimbursement: an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). You must submit this information on a MedTrak Direct Member Reimbursement Claim form. This claim form is located on the MedTrak Internet site at [www.medtrakservices.com](http://www.medtrakservices.com) or you can call the HIRSP Dedicated Pharmacy Unit toll-free at 1-800-757-5576 to request a form. In these situations, you may be charged more than the HIRSP drug copayment amount. The PBM will determine the benefit amount based on the HIRSP rate for the covered drug, less any applicable coinsurance.

Except as specifically provided, all provisions of this policy, including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. If you have any questions, please contact the PBM about these benefits.

Cost-effective generic equivalents will be dispensed unless the health care provider specifies the brand-name drug, indicates that no substitutions may be made, and completes the required Medical Exception process.

**(1) Prescription Drugs.**

- (a) Prescription Drugs Other than Maintenance Drugs and Specialty Drugs.** Prescription drugs, other than those prescription drugs purchased from a maintenance medication network pharmacy or specialty drugs, must be purchased from a PBM network pharmacy.

The medical benefit, not the prescription drug benefit, will be responsible for covering prescription drugs administered during home care, office setting, confinement, emergency room visit or urgent care setting, if otherwise covered under this policy. However, prescriptions for covered drugs written during home care, office setting, confinement, emergency room visit or urgent care setting will be the responsibility of the PBM, unless otherwise specified in this policy (for example, self-administered injectable).

Smoking cessation drugs shall be limited to a maximum benefit limit of \$500 per calendar year.

- (b) Maintenance Drugs.** In order to obtain a 90-day supply of maintenance drugs, other than specialty drugs, the policyholder must receive those drugs from a maintenance medication network pharmacy, subject to the applicable copayment. The physician must indicate a 90-day supply on the prescription in order for the policyholder to receive a 90-day supply.
- (c) Specialty Drugs.** Specialty drugs must be dispensed by a specialty pharmacy. Benefits are not payable under this policy for specialty drugs when dispensed by a pharmacy other than a specialty pharmacy.

Prescription drugs will be dispensed as follows:

- (a)** In maximum quantities not to exceed a 30-day supply for prescription drugs received at the retail or specialty pharmacy or a 90-day supply for maintenance drugs dispensed by a maintenance medication network pharmacy.
- (b)** Single packaged items are limited to two items or 30-day supply (six items or 90-day supply dispensed by a maintenance medication network pharmacy), whichever is more appropriate, as determined by the PBM.
- (c)** Prior authorization from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring prior authorization is available from the PBM.
- (d)** Cost-effective generic equivalents will be dispensed unless the health care provider specifies the brand name drug, indicates that no substitutions may be made, and completes the required medical exception process.

- (e) Generic Copay Waiver Program is available to encourage the use of generic drugs, whereby the PBM may waive the HIRSP drug copayment of a generic prescription drug for a period of up to six months.
  - (f) The PBM reserves the right to designate certain over-the-counter drugs on the formulary.
  - (g) Self-administered injectables must be obtained from a specialty pharmacy.
- (2) **Insulin, Disposable Diabetic Supplies, Glucometers and Other Devices and Supplies.**
- (a) Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30-day supply for insulin received at the pharmacy or a 90-day supply for insulin dispensed by a maintenance medication network pharmacy.
  - (b) Disposable diabetic supplies and glucometers will be covered when prescribed for treatment of diabetes and purchased from a PBM network pharmacy or a maintenance medication network pharmacy. Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The applicable HIRSP drug copayment will be applied to the annual out-of-pocket maximum for prescription drugs.
  - (c) Other non-diabetic devices and supplies administered by the PBM that are subject to the applicable HIRSP drug copayment are as follows: syringes, needles, spacers, and peak flow meters.

Devices and supplies described in (a) and (c) above will be subject to the HIRSP medical deductible and HIRSP medical coinsurance if they are provided by a provider other than a PBM network pharmacy or maintenance medication network pharmacy.

- c. **Refill Policy.** Refills of a prescription are a covered service if they meet the following criteria:
- (1) Prescriptions for drugs that are not controlled substances (non-schedule drugs) are limited to the original dispensing plus 11 refills within 12 months. A new prescription is required after 12 months even if all refills have not been dispensed.
  - (2) Refills for drugs that are controlled substances with the potential for abuse (e.g., Schedule III, IV, and V drugs as defined in Sections 961.17-961.22, Wisconsin Statutes, as amended) are limited to the original dispensing plus five refills within six months. A new prescription is required after six months even if all refills have not been dispensed.

#### 14. **Durable Medical Equipment.**

Rental of or, at the option of HIRSP, purchase of durable medical equipment such as, but not limited to: wheelchairs; hospital-type beds; and artificial respiration equipment, including oxygen equipment. Benefits shall include the purchase of batteries to operate the durable medical equipment. Coverage for such equipment and devices will be limited to the standard models as determined by HIRSP. You are responsible for paying any amount in excess of the allowed amount for the standard models. When the durable medical equipment is purchased, benefits are payable for subsequent repairs necessary to restore the durable medical equipment to a serviceable condition. If the durable medical equipment is rented, HIRSP will pay benefits for the

allowed amount up to the purchase price of that durable medical equipment. Rental fees exceeding the purchase price and routine periodic maintenance are not covered.

The Plan Administrator's prior approval is required for any durable medical equipment that will be rented for more than three months or with a purchase price greater than \$1,500. If you do not receive the Plan Administrator's prior approval in accordance with subsection "E. Prior Approval of Health Care Services," benefits for such durable medical equipment will not be payable under this policy.

**15. Genetic Services.**

Benefits are payable for charges for the following genetic services:

- a. Genetic counseling provided to you by a physician, licensed genetic counselor or medical geneticist;
- b. amniocentesis during pregnancy;
- c. chorionic villus sampling for genetic and non-genetic testing during pregnancy;
- d. identification of infectious agents such as the influenza virus;
- e. molecular testing of pathological specimens. Such testing does not include any testing of blood, except for (a) testing for the diagnosis of leukemia, lymphoma, or platelet abnormalities and (b) testing of the KRAS genetic variation for drug susceptibility; and
- f. (5) CF (cystic fibrosis) testing up to 23 mutations for cystic fibrosis for policyholders who are pregnant; and
- g. for the diagnosis or treatment of one of the illnesses listed below. The Plan Administrator's prior approval is required for such genetic tests. If you do not receive our prior approval in accordance with subsection E. Prior Approval of Health Care Services, benefits for such services are not payable under this policy and such services are not covered.

Benefits are payable if the disease being tested for is one of the following:

- (1) Canavan Disease;
- (2) Congenital Profound Deafness;
- (3) Cystic Fibrosis for policyholders who are not pregnant;
- (4) Factor V Leiden Thrombophilia;
- (5) Familial Adenomatous Polyposis Coli;
- (6) Gaucher Disease;
- (7) Hemoglobinopathies;
- (8) Hereditary Hemochromatosis;
- (9) Hereditary Non-Polyposis Colorectal Cancer;
- (10) Long QT Syndrome;
- (11) Mitochondrial Disorders;
- (12) Myotonic Dystrophy;
- (13) Niemann-Pick Disease;
- (14) Retinoblastoma;

- (15) Medullary Thyroid Cancer and Multiple Endocrine Neoplasia Type 2 RET testing;
- (16) Breast and Ovarian Cancer Susceptibility;
- (17) Tay-Sachs Disease; or
- (18) Von Hippel-Lindau Disease.

Since this list may change from time to time, you should contact the Plan Administrator by calling the Customer Service telephone number shown on your WPS Identification Card, or log on to our internet website at [www.wpsic.com](http://www.wpsic.com), for the most current list of covered diagnoses for genetic testing.

Genetic testing for the following will not be covered: (1) testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone; (2) testing for conditions which can not be altered by treatment or prevented by specific interventions; (3) testing solely for the purpose of informing the care or management of your family members; (4) testing for drug therapy, i.e. pharmacogenetics; and (5) genetic testing for any condition that does not appear on the above list or as updated on the WPS Internet website.

**16. Health and Behavior Assessments.**

Health and behavior assessments and reassessments and neuropsychological testing provided by a psychologist to treat a physical illness or injury.

**17. Hearing Aids and Cochlear Implants.**

Benefits are payable for charges for: (a) the cost of one hearing aid, per ear, per child every three years; (b) cochlear implants; and (c) treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear implants. This paragraph applies only to children under the age of 18 who are covered under this policy. Such hearing aids and cochlear implants must be prescribed by a physician or an audiologist in accordance with accepted professional medical or audiological standards.

The child must be certified as deaf or hearing impaired by a physician or audiologist.

**18. Home Care.**

**a. Covered Services.**

This paragraph 17. applies only if the charges for home care services are not covered elsewhere under this policy. A Department-licensed or Medicare-certified home health agency or certified rehabilitation agency must provide or coordinate the services. You should make sure the agency meets this requirement before services are provided. Benefits are payable for the allowed amount for the following services:

- (1) Part-time or intermittent home nursing care by or under supervision of a Medicaid-certified registered nurse;
- (2) Part-time or intermittent home health aide services when part of the home care plan. The services must consist solely of care for the patient. A Medicaid-certified registered nurse or medical social worker must supervise them;
- (3) Physical or occupational therapy or speech-language pathology or respiratory care;

- (4) Medical supplies, drugs and medications prescribed by a physician; laboratory services by or on behalf of a hospital if needed under the home care plan. These items are covered to the extent they would be if you had been hospitalized;
- (5) Nutrition counseling provided or supervised by a Medicaid-certified physician, registered, pharmacist, certified dietician, or other provider; and
- (6) Evaluation of the need for a home care plan by a provider who may be a registered nurse, physician extender, physician assistant, nurse practitioner, or medical social worker. Your attending physician must request or approve this evaluation.

**b. Limits on Home Care.**

- (1) Home care isn't covered unless your physician certifies that: (1) hospitalization or confinement in a licensed skilled nursing facility would be needed if you didn't have home care; and (2) members of your immediate family, or others living with you, couldn't give you the care and treatment you need without undue hardship.
- (2) If you were hospitalized just before home care started, your physician during your hospital confinement must also approve the home care plan.
- (3) HIRSP will pay benefits for the allowed amount for up to 40 home care visits in a calendar year for policyholders in HIRSP 1,000, HIRSP 2,500 AND HIRSP 5,000 and 365 home care visits in a calendar year for policyholders in HIRSP Medicare Supplement. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.

**19. Hospice Care.**

HIRSP will pay benefits for the allowed amount for covered expenses for hospice care services provided to a terminally ill policyholder if his/her health condition would otherwise require his/her confinement in a hospital or a skilled nursing facility and hospice care is a cost effective alternative, as determined by the Plan Administrator. Hospice care services include services intended primarily to provide pain relief, symptom management, and medical support services to persons who are terminally ill. Hospice care services may be provided at hospice facilities or in your place of residence.

Covered expenses for hospice care services shall include: (a) room and board at a hospice facility while you are receiving acute care to alleviate physical symptoms of his/her terminal illness; (b) physician and nursing care; and (c) services provided to you at your place of residence. Room and board for residential care at a hospice facility is not covered.

HIRSP will pay benefits for the allowed amount for covered expenses for hospice care services provided to you during the initial six-month period immediately following the diagnosis of a terminal illness for that policyholder. Coverage for hospice care services to be provided to you after the initial six-month period will be extended by the Plan Administrator under this policy beyond the initial six month period, provided, a physician certifies in writing that you are terminally ill.

**20. Hospital Services.**

You must obtain the Plan Administrator's prior approval for a non-emergency hospital confinement in accordance with Section X. Care Management Program before you receive any inpatient hospital services. If you do not receive the Plan Administrator's prior approval before your confinement, benefits for inpatient hospital services will not be payable for that confinement.

- a. Inpatient hospital services for a physical illness or injury and for detoxification of drug addiction or alcohol dependency. Benefits are payable for the allowed amount for hospital room and board, nursing services, miscellaneous hospital expenses, and intensive care unit room and board.

With respect to confinements for pregnancy, the policy shall not limit the length of stay to less than: (1) 48 hours for a normal birth; and (2) 96 hours for a cesarean delivery. However, you are free to leave the hospital earlier if the decision to shorten the stay is the mutual decision of the physician and mother.

- b. Miscellaneous hospital expenses for a physical illness or injury received by you while you are not confined in a hospital. These don't include charges for outpatient physical, speech, occupational or respiratory therapy.
- c. Facility fees charged by the hospital for office visits and for urgent care visits.

**21. Kidney Disease.**

Hospital inpatient and outpatient treatment of kidney disease, including dialysis, and donor-related services. The following conditions apply:

- a. Benefits are in lieu of any other hospital benefits for kidney disease payable under this policy.
- b. Total benefits payable under this item, including any other kidney disease benefits the policyholder may receive from this policy, cannot exceed \$30,000.00 in any one calendar year.

**22. Lenses and Frames.**

Initial purchase of eyeglasses or contact lenses for aphakia or keratoconus and initial purchase following cataract surgery.

**23. Medical Supplies.**

Medical supplies prescribed by a physician, including, but not limited to:

- a. ostomy bags and supplies, except charges such as those made by a pharmacy for purposes of fitting are not covered;
- b. diabetic urine and blood testing supplies;
- c. dressings;
- d. elastic bandages and tubular elastic bandages when billed by a Medicaid-certified home care provider or the physician's office;
- e. gastric feeding/enteral sets and supplies. HIRSP does not cover over-the-counter food or nutritional products;
- f. catheters and irrigation apparatus;
- g. parenteral supplies;
- h. tracheostomy and endotracheal care supplies;
- i. ventilator supplies;
- j. transcutaneous Electrical Nerve Stimulation (TENS) supplies if HIRSP covered the TENS unit;
- k. purchase of prescription surgical compression stockings of 12 to 15 millimeters mercury (mmHg) compression (surgical weight) at the ankle or greater. The number of pairs covered is determined by what HIRSP determines is medically necessary and appropriate

(normally six a year), but only two pairs may be issued at one time. You will pay the difference of the cost of any product over and above that which HIRSP determines is medically necessary and appropriate; and

- i.** strapping; crutches.

**24. Nutritional Counseling.**

Nutritional counseling for a member who is diagnosed with morbid obesity or any other diet-related chronic illness, other than an eating disorder such as bulimia or anorexia nervosa. Such counseling must be provided by a physician, a dietician or nutritionist licensed in the state where the counseling is provided to the member. Please see paragraph "1. Alcoholism, Drug Abuse and Nervous or Mental Disorders" for benefits for nutritional counseling for eating disorders.

**25. Orthoptics.**

Orthoptics (eye exercise training) when used for convergence insufficiency, strabismus, and amblyopia. HIRSP covers a maximum of two visits.

**26. Orthotic Devices and Appliances.**

Orthotic devices including fittings and adjustments of custom-made rigid or semi-rigid supportive devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. Covered orthotic devices include, but are not limited to:

- a.** Casts, splints and orthopedic braces;
- b.** Cervical collars;
- c.** Ankle orthosis;
- d.** Corsets (back and special surgical);
- e.** Wristlets; and
- f.** Diabetic shoes when such diabetic shoes are medically necessary.

However, orthotic devices or appliances to support the foot are not covered unless: (a) they are a permanent part of an orthopedic leg brace; or (b) you are diagnosed with planter fasciitis.

Orthotic appliances may be replaced once per calendar year when medically necessary. However, additional replacements will be allowed for policyholders under age 18 due to rapid growth, or for any policyholder when an appliance is damaged and can not be repaired.

This policy does not cover routine periodic maintenance, such as testing, cleaning and checking of the device.

**27. Oxygen.**

Oxygen

**28. Pain Management Treatment.**

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

The Plan Administrator's prior approval is required for the following pain management injections or procedures:

- a. percutaneous intervertebral disc procedures (intradiscal electrothermal therapy (IDET), intradiscal electrothermal annuloplasty (IDEA), percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), nucleoplasty, laser assisted disc decompression (LADD), percutaneous disc decompression, chemonucleolysis;
- b. radiofrequency neuroablation (neurolysis) of the facet joint nerves;
- c. facet joint injections and medical branch nerve blocks;
- d. trigger point injections;
- e. epidural injections, other than epidural injections provided to the pregnant participant in connection with labor or delivery of a newborn child or due to surgery; and
- f. sacroiliac joint injections;
- g. artificial intervertebral disc replacement (lumbar artificial disc replacement (LADR) and intervertebral disc prosthesis.

If you do not receive the Plan Administrator's prior approval in accordance with subsection "E. Prior Approval of Health Care Services," benefits for such pain management injections and procedures are not payable under this policy.

**29. Preventive Services.**

Preventive services include:

- a. Immunizations including, but not limited to, the following: diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; and varicella. Benefits are payable for such immunizations at 100% of the allowed amount for policyholders up to age six. The annual deductible amounts do not apply to those immunizations up to age six. For policyholders age six and over, benefits are payable for such immunizations subject to the applicable deductible, coinsurance and annual out-of-pocket mounts. Immunizations for travel purposes are not covered.
- b. Routine medical exams, excluding routine eye exams and routine hearing exams. This paragraph does not apply to health care services to treat an illness or injury.
- c. Routine diagnostic procedures. Examples include diagnostic x-rays, complete blood count, total blood cholesterol test, thyroid function test, HIV antibody test, urinalysis, pap test, pelvic examination, bone density testing, and prostate cancer screening. This paragraph does not apply to health care services to treat an illness or injury.
- d. Routine examination by low-dose mammography of a female policyholder per calendar year. Mammograms must be performed by or under the direction of a Medicaid-certified physician, certified nurse midwife or licensed nurse practitioner.
- e. Blood lead tests for policyholders age five and under.
- f. Alcohol misuse and depression screening.

Benefits are payable at 100% of the charges for b. through f. above, without application of the annual deductible amounts, up to a maximum of \$150 per calendar year. After that maximum is met, benefits will continue to be payable subject to applicable deductible, coinsurance and out-of-pocket provisions of this policy.

**30. Professional Services.**

Benefits are payable for the following professional services. This subsection does not include services for the treatment of alcoholism, drug abuse or nervous or mental disorders or services for covered transplants. Please see paragraph "1. Alcoholism, Drug Abuse and Nervous or Mental Disorders", paragraph "21. Kidney Disease" and paragraph "36. Transplants."

- a. Surgical services, other than oral surgical services, wherever performed.
- (1) Benefits are payable for a covered surgical procedure that requires a surgical assistant to be present, as determined by the Plan Administrator, only as follows. If the Plan Administrator determines benefits are payable for the services directly provided to you by a surgical assistant: (a) benefits for the covered services of a physician surgical assistant will be paid up to a maximum of 25% of the allowed amount the Plan Administrator determines for that surgical procedure performed by the physician; and (b) benefits for the covered services of a surgical assistant who is not a physician will be paid up to a maximum of 10% of the allowed amount the Plan Administrator determines for that surgical procedure performed by the physician.
  - (2) Benefits payable for covered bilateral surgical procedures done at the same setting are limited to a maximum of one and one-half times the allowed amount the Plan Administrator determines for the single surgical procedure. No additional benefits are payable for those procedures. A bilateral surgical procedure is the same surgical or invasive medical procedure performed on similar anatomical parts which are on opposite sides of a body which are usually identified as either right or left (e.g. eyes, ears, arms, legs, hands, feet, breasts, lungs or kidneys).
  - (3) Benefits payable for covered multiple surgical procedures, other than bilateral surgical procedures, are limited to a maximum of 100% of the allowed amount the Plan Administrator determines for the primary surgical procedure and 50% of the allowed amount the Plan Administrator determines for each additional procedure, other than procedures determined to be incidental or inclusive. A primary surgical procedure is the surgical procedure with the highest charge as determined by the Plan Administrator. Multiple surgical procedures are more than one surgical or invasive medical procedure performed at the same setting, usually within the same related anatomical region, or same incisional area.
  - (4) Benefits are not payable for incidental or inclusive surgical procedures which are performed at the same setting as a major covered surgical procedure, which is the primary procedure. Incidental or inclusive surgical procedures are one or more surgical procedures performed through the same incision or operative approach as the primary surgical procedure with the highest charge as determined by the Plan Administrator and which are determined to be not clearly identified and/or do not add significant time or complexity to the surgical session. Benefits payable for incidental surgical procedures are limited to the allowed amount for the primary surgical procedure with the highest charge, as determined by the Plan Administrator. No additional benefits are payable for those incidental surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an incidental surgical procedure (i.e., benefits are payable for the hysterectomy, but not for the removal of the appendix).
  - (5) Benefits are payable for surgical services for morbid obesity, as defined in this policy, including gastroplasty and gastric bypass surgery, provided the policyholder meets all criteria established by the Plan Administrator.

The Plan Administrator's prior approval is required for any surgical services for morbid obesity. If you do not receive the Plan Administrator's prior approval in accordance with subsection "E. Prior Approval of Health Care Services," benefits for such surgical services will not be payable under this policy.

- b. Medical services for a physical illness or injury, including second opinions. Services must be provided: (1) in a hospital; (2) in a physician's office; (3) in an urgent care center; (4) in a surgical care center; (5) convenient care clinic; or (6) in your home. These services do not include home care services covered under paragraph "18. Home Care."

Prescription drugs, including injections, that can be self-administered and/or can be provided to you by a pharmacy are not covered under this paragraph, unless approved by the Plan Administrator.

- c. Anesthesia services provided in connection with other health care services covered under this policy.
- d. Maternity services provided by a physician, nurse practitioner or certified nurse midwife. Maternity services are: (1) prenatal and postnatal care; (2) laboratory procedures; (3) delivery of the natural newborn child; (4) cesarean sections; (5) health care services for miscarriages; and (6) nuchal translucency test (ultrasound).

An abortion procedure for the termination of a mother's pregnancy is covered only if: (1) the pregnancy is considered a life-threatening complication of the mother's existing physical illness; or (2) due to a lethal fetal anomaly; and (3) the abortion procedure is permitted by, and performed in accordance with, law. "Lethal fetal anomaly" is defined as an anomaly which predictably results in fetal demise either in utero or shortly (within 72 hours) after delivery.

- e. Diagnostic radiology and laboratory services directly provided to you for radiology and lab tests related to covered physical illness or injury.  

The Plan Administrator's prior approval is required for any non-emergency PET scan or MRA study. If you do not receive the Plan Administrator's prior approval in accordance with subsection "E. Prior Approval of Health Care Services," benefits for non-emergency PET scan or MRA study will not be payable under this policy.
- f. Radiation therapy and chemotherapy services for therapeutic treatment of covered benign or malignant conditions, including charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in treatment.

**31. Prosthetics.**

Prosthetic devices and supplies, including the fitting of such devices, which replace all or part of: (a) an absent body part (including contiguous tissue); or (b) the function of a permanently inoperative or malfunctioning body part. This policy does not cover dental prosthetics.

The Plan Administrator's prior approval is required for any prosthetic with a purchase price greater than \$1,500. If you do not receive the Plan Administrator's prior approval in accordance with subsection "E. Prior Approval of Health Care Services," benefits for such prosthetics will not be payable under this policy.

**32. Radioactive Materials.**

Use of radium and radioactive materials.

**33. Skilled Nursing Care in a Licensed Skilled Nursing Facility.**

Benefits are payable for the allowed amount for skilled nursing care you receive in a licensed skilled nursing facility.

If you are enrolled in other than HIRSP Medicare Supplement, benefits are payable for such skilled nursing care provided to the confined policyholder at that facility for up to 30 days of confinement for that policyholder. A covered period of confinement in a licensed skilled nursing facility begins as follows:

- a. At least 60 days after the policyholder was last confined in a licensed skilled nursing care facility for skilled nursing care for the injury or illness that caused the prior confinement.
- b. Anytime a confinement in a licensed skilled nursing care facility is not related to any cause of a previous confinement.

If you are enrolled in HIRSP Medicare Supplement, HIRSP will not pay more than a total of 120 days in any one calendar year. This expense must be of the type reimbursable under Medicare.

**34. Temporomandibular Joint Dysfunction (TMJ).**

Benefits are payable for the allowed amount for diagnostic procedures and medically necessary surgical and non-surgical treatment for the correction of temporomandibular disorders if all of the following apply:

- a. the condition is caused by congenital, developmental or acquired deformity, disease or injury;
- b. under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition; and
- c. the purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

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

Benefits are not payable for cosmetic or elective orthodontic care, periodontic care or general dental care.

**35. Therapies.**

Benefits for therapy services are limited to the following:

- a. Outpatient physical, speech, respiratory, and occupational therapy. The therapy must be expected to significantly improve your physical health within 60 days of the date on which such therapy begins. The therapy must be performed by a physician, licensed physical, speech or occupational therapist, or any other health care provider approved by HIRSP. The licensed physical, speech, respiratory, and occupational therapist or other health care provider must be providing the therapy under the direction of your physician. If a license to perform such therapy is required by law, that therapist or other health care provider must be licensed by the state in which he/she is located and must provide such therapy while he/she is acting within the lawful scope of his/her license. Physical therapy for your temporomandibular joint disorder is not covered under this subsection.
- b. Aquatic therapy that is physical therapy in water and is prescribed by a physician and provided by a licensed physical therapist.
- c. Massage therapy when prescribed by a physician and provided by a licensed physical therapist.
- d. Intravenous (IV) therapy/infusion therapy performed in your home if prescribed by a physician. Home IV therapy or home infusion therapy includes, but is not limited to, injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), and antibiotic therapy.

The Plan Administrator's prior approval is required for home IV therapy. If you do not receive the Plan Administrator's prior approval in accordance with subsection "E. Prior Approval of Health Care Services," benefits for such IV therapy will not be payable under this policy.

**36. Transplants.**

Benefits are payable for charges for medically necessary transplant services for a covered transplant procedure shown below. These transplant services must be due to an injury or illness covered under this policy. Benefits are payable only if the transplant procedure is approved by the Plan Administrator based on our interpretation and application of the Plan Administrator's guidelines, protocols, and other requirements applicable to that transplant procedure that are in effect at the time the Plan Administrator is notified about that transplant procedure.

All transplant services require the Plan Administrator's prior approval in accordance with subsection "E. Prior Approval of Health Care Services" before you receive any of the services. You must contact us as soon as you are scheduled for a transplant evaluation. Please call us at the telephone number shown in that subsection. If you do not receive our prior approval before you receive any of the services, benefits for covered transplant services are not payable under this policy.

You must obtain and submit to the Plan Administrator a written opinion certifying the medical need for the transplant procedure. The opinion must be received by the Plan Administrator prior to the transplant procedure. The opinion must be given by a board-certified medical specialist who is a physician. For solid organ transplants, the opinion must be provided by a board-certified surgeon. For bone marrow transplants, the opinion must be provided by a board-certified hematologist or board-certified oncologist. The board-certified medical specialist must certify that alternate procedures, services or courses of treatment would not be medically therapeutic in the treatment of your illness or injury.

Benefits are payable for the following transplants:

- a. Bone marrow/stem cell.
- b. Cornea.
- c. Heart.
- d. Heart/lung.
- e. Intestine.
- f. Kidney.
- g. Liver.
- h. Lung.
- i. Pancreas.
- j. Kidney/pancreas, kidney/liver.

HIRSP will also pay donor benefits associated with donating the organ to the policyholder.

In addition to other limitations indicated in this policy, the following limitations apply:

- a. The aggregate lifetime maximum benefit limit per recipient for all bone marrow, organ or tissue transplant services for all covered transplant procedures is \$500,000. However, benefits paid under this paragraph for a covered single kidney transplant will continue to be payable up to a maximum of \$30,000 per calendar year for each member. The aggregate lifetime maximum benefit limit applies to all covered illnesses, injuries, complications or side effects related to or caused by a covered transplant procedure and treatment thereof (including donor costs), or which necessitated the transplant surgery

even though covered elsewhere under this policy. If a recipient reaches the aggregate lifetime maximum benefit limit, no further benefits are payable under this subsection for any transplant services and transplant drugs provided to that recipient.

- b. The organ must be from a human donor.
- c. HIRSP does not cover the purchase price of an organ that is sold, rather than donated, to the policyholder.

## **Section X. Care Management Program**

The HIRSP coverage has a care management program. Please read this section very carefully. If you do not follow the procedures described below, benefits for health care services you incur may not be covered under the HIRSP policy if those health care services are determined to be not medically necessary or experimental or investigative in nature.

### **A. Hospital Admission Authorization**

This subsection does not apply to the HIRSP Medicare Supplement plan.

#### **1. Non-Emergency Hospital Admission.**

You, or your family member, physician, hospital or other health care provider acting on your behalf, must notify the Plan Administrator at least three business days before you are admitted to a hospital for non-emergency care. This starts the process of hospital admission review. The Plan Administrator will authorize your admission if it is medically necessary, or deny it if it is not medically necessary.

If you or your family member, physician, hospital or other health care provider on your behalf fails to notify the Plan Administrator of the proposed hospitalization in advance as required above, benefits will be reduced by \$500 for that confinement.

#### **2. Hospital Emergency Admission.**

You, or your family member, physician, hospital or other health care provider acting on your behalf, should notify the Plan Administrator within two business days of your hospital admission for emergency care. The Plan Administrator will authorize your admission if it is medically necessary, or deny it if it is not medically necessary.

### **B. Prenatal and Maternity Care Notification**

If you are pregnant, the Plan Administrator requests that the Plan Administrator be notified:

- 1. after your first prenatal visit; and
- 2. within 24 hours or the first business day following the date of your delivery.

Although your failure to provide such notice won't reduce benefits otherwise payable for such health care services, notice to the Plan Administrator will allow the Plan Administrator to work with you and your physician during your pregnancy to help coordinate medically necessary health care services and provide high-risk screening and health information.

### **C. Individual Case Management**

#### **1. Alternate Treatment.**

From time to time the Plan Administrator may, at its option, suggest that you consider an alternate treatment for their covered illness or injury which differs from their current treatment of that illness or injury if it appears that the alternative treatment is not subject to an exclusion of this policy and:

- a. the alternate treatment offers a medical therapeutic value at least equal to the current treatment;
- b. the current treatment may be changed without jeopardizing your health; and
- c. the charges incurred for services to be provided under the alternate treatment to its end will probably be less than those charges to be incurred for services to be provided under the current treatment.

The Plan Administrator will contact your attending physician to: (a) suggest consideration of the alternate treatment; (b) advise the physician of the possible benefits payable by the Plan Administrator for the allowed amount for such treatment; and (c) answer any questions the attending physician may have.

The Plan Administrator will then send a letter to both you (or your authorized representative) and the attending physician. That letter will provide a description of the alternate treatment and an estimate of the possible benefits payable by the Plan Administrator for the charges to be incurred for such treatment.

If you or your authorized representative and the attending physician agree to the alternate treatment, the letter must be signed by you or your authorized representative and your attending physician. The signed letter must be promptly returned to the Plan Administrator. The alternate treatment must begin as soon as reasonably possible. If you or your authorized representative and/or the attending physician do not agree with the alternate treatment, benefits for the allowed amount incurred for the current treatment remain payable as provided under this policy. Acceptance of the alternate treatment does not prevent a change in treatment at any time thereafter.

## **2. Alternate Confinement**

From time to time the plan administrator may, at its option, suggest that the policyholder, while confined in a hospital for a covered illness or injury, consider a transfer to another institution if it appears that the alternative confinement is not subject to an exclusion of the policy and:

- a. the other institution can provide the necessary medical care;
- b. the physical transfer would not jeopardize your health and the medical effectiveness of the current confinement; and
- c. the allowed amount to be incurred for the alternate confinement at the other institution will probably be less than those allowed amounts to be incurred for continued confinement at the current hospital.

The Plan Administrator will contact your attending physician to: (a) suggest consideration of the alternate confinement; (b) advise the physician of the possible benefits payable by the plan administrator for the allowed amount for such confinement; and (c) answer any questions the attending physician may have.

The Plan Administrator will then send a letter to both you (or your authorized representative) and the attending physician. That letter will provide a description of the alternate confinement and an estimate of the possible benefits payable by the Plan Administrator for the allowed amount to be incurred for such confinement.

If you or your authorized representative and the attending physician agree to the alternate confinement, the letter must be signed by you or your authorized representative and your attending physician. The signed letter must be promptly returned to the Plan Administrator. The alternate confinement must begin as soon as reasonably possible. If you or your authorized representative and/or the attending physician do not agree with the alternate confinement, benefits for the allowed amount incurred for the current confinement remain payable as provided under

this policy. Acceptance of the alternate confinement does not prevent a change in confinement at any time thereafter.

**D. Disease Management Programs**

Policyholders who are pregnant or who have chronic health conditions may benefit from the Plan Administrator's programs that can help them manage their conditions including:

1. diabetes;
2. heart and lung diseases (coronary artery disease and congestive heart failure);
3. asthma (adult and pediatric);
4. depression; and
5. alcohol and substance abuse.

The Plan Administrator's disease management programs offer one-on-one counseling and/or disease education. At the heart of this patient-focused, personalized approach is a team of experienced nurses, social workers, and an alcohol and substance abuse counselor, whose ongoing support:

1. empowers you to take a more active role in your own disease management therapy through the Plan Administrator's education programs and communication materials;
2. improves compliance with prescribed therapies;
3. enhances both clinical and medical resource outcomes.

Under this policy, potential disease management candidates are identified through the Plan Administrator's claims processing system by diagnosis codes or by a referral from a family member, health care provider or HIRSP staff. To learn more about the Plan Administrator's disease management programs, please call 866-841-6572 and ask to speak to a disease manager.

## **Section XI. General Exclusions**

The following are not covered under this policy.

**A. Inpatient Health Care services Not Covered by HIRSP**

1. Hospital stays that are extended for reasons that are not medically necessary and appropriate (e.g., lack of transportation, lack of care giver, inclement weather, bed not available in another facility).
2. An inpatient stay, if HIRSP determines that care could be provided effectively in a less acute care setting, such as a skilled nursing care facility.
3. Room, board, services and supplies that are furnished to you by a hospital on the Friday and Saturday of the weekend of hospital admission if you are admitted as a registered resident patient to the hospital on one of those days, unless your hospital admission is medically necessary or such admission is required to provide you with emergency medical care of a covered illness or injury.

**B. Medical-Surgical Services Not Covered by HIRSP**

1. Routine examinations, unless specifically stated in this policy as covered services, including:
  - a. Physical examinations.
  - b. Dental examinations.
  - c. Examinations to determine the need for eyeglasses and hearing aids.



18. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related hospital, professional, and diagnostic services and medications that are incidental to such insemination and fertilization methods. In addition, infertility diagnostic services or infertility evaluation and management services, and related services that are provided after the commencement of your infertility treatment are not covered under this policy. The diagnosis of infertility alone does not constitute an illness.
19. Health care services, including, but not limited to, surgical services, devices and drugs for, or used in connection with, sexual dysfunction, including, but not limited to, impotence, or for the purpose of enhancing or affecting sexual performance, regardless of whether the origin of the sexual dysfunction is organic or psychological in nature, including, but not limited to, Viagra, Caverject, MUSE, Yohimbine, Femprox or their generic equivalent, penile implants and sex therapy.
20. Sterilization procedures; reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.
21. Amniocentesis, chorionic villus sampling (CVS), ultrasound, or other tests solely for sex determination.
22. Health care services provided: (a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet which are billed as routine and not associated with a medical diagnosis; (b) in the cutting or trimming of toenails which are billed as routine or associated with a medical diagnosis, except for the medical diagnosis of diabetes; (c) in the non-operative partial removal of toenails which are billed as routine or not associated with a medical diagnosis.
23. Abortion procedures for the termination of pregnancy, except as specifically stated in Section IX. B. 30.
24. Health care services for, or used in connection with, transplants of human and non-human body parts, tissues or substances, implants of artificial or natural organs or any complications of such transplants or implants, except as specifically stated in Section IX. B. 36.
25. Genetic testing, except as specifically stated in Section IX. B. 15.
26. Prescription drugs, including injections, provided in a physician's office, outpatient department of a hospital or by a home health agency that can be self-administered and/or can be provided to you by a pharmacy are not covered under this policy, unless approved by the Plan Administrator.

**C. Equipment Not Covered by HIRSP**

1. Preparation, fitting or purchase of hearing aids and other internal or external hearing devices, including related services and supplies (e.g., batteries).
2. Medical supplies and durable medical equipment for your comfort, personal hygiene or convenience, including, but not limited to, air conditioners, air cleaners, humidifiers, physical fitness equipment, physician's equipment, disposable supplies, other than colostomy supplies, alternative communication devices, or self-help devices not medical in nature.
3. Durable medical equipment or prostheses that HIRSP determines are or have features over and above that which are medically necessary and appropriate or reasonable for the policyholder.
4. Stair lifts and motor vehicles (e.g., cars, vans) or customization of vehicles, lifts and ramps for wheel chairs and scooters.
5. Durable medical equipment, devices, or supplies approved by the FDA but not yet determined by HIRSP to be medically necessary and appropriate or non-experimental.

**D. Medical Supplies Not Covered by HIRSP**

1. Home testing and monitoring supplies other than diabetic supplies.
2. TENS supplies when HIRSP did not cover the TENS unit.
3. Foot orthotics, other than for policyholders diagnosed with diabetes or plantar fasciitis.
4. Special shoes (other than diabetic shoes when such diabetic shoes are medically necessary) or devices, unless they are a permanent part of an orthopedic leg brace.

**E. Therapies Not Covered by HIRSP**

1. Health care services used in educational or vocational training or testing, including work hardening programs.
2. Coma stimulation programs.
3. Aqua therapy, except as specifically stated in Section IX. B. 35.
4. Massage therapy, except as specifically stated in Section IX. B. 35.
5. Physical fitness or exercise programs, except as specifically stated in Section IX. B. 8..
6. Recreational therapy and educational therapy.

**F. Drugs Not Covered by HIRSP**

The exclusions listed in this subsection apply to the drug benefits described in Section IX. B. 13. b.

1. Over-the-counter medications, except insulin and those listed in the formulary.
2. Prescription drugs that have an over-the counter equivalent.
3. Supplies and medicines you buy with or without a physician's prescription, unless otherwise specifically covered.
4. Prescription drugs which require prior authorization unless approved by the PBM.
5. Cosmetic Retin-A, Rogaine, and Propecia, or their medical equivalent, any medications specifically prescribed for weight loss (for example, appetite suppressants), anorexic agents, non-FDA approved oral progesterone and all over the counter drug items, except nicotinic acid and those designated as covered by the PBM.
6. Compounded products to include compounded estrogen, progesterone or testosterone for oral or sublingual administration, compounded drugs that contain a Less-Than-Effective (LTE) drug, compound prescriptions that result in drug combinations that the FDA considers LTE.
7. Drugs that HIRSP determines are experimental or not medically necessary and appropriate.
8. Unit dose medication, which includes bubble pack or pre-packaged medications for convenience purposes, except for medications that are unavailable in any other dose or packaging.
9. Administration of a covered drug by injection or other means; covered drugs completely consumed at the time and place of the provider's dispensing the drugs under the prescription orders.
10. Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutic Committee which determines the therapeutic advantage of the drug and the medically appropriate application.
11. Infertility, fertility, and sterility medications and drugs used for impotence and/or reduced libido.
12. Medications obtained through a discount program or over the Internet, unless prior authorization is obtained from HIRSP.

13. Spilled, stolen or lost prescriptions.
14. Micronized progesterone.
15. Alcoholic beverages, even if prescribed for remedial or therapeutic reasons.
16. Sex hormones related to sex transformations.
17. Supplies and medicines purchased from a non-network pharmacy.
18. Bleaching agents, such as Melanex, Eldoquin, and Solaquin, that HIRSP considers to be cosmetic.
19. For HIRSP Medicare Supplement policyholders, drugs not listed in the Medicare Part D formulary, except for those drugs that are not listed in the Medicare Part D formulary due to a specific exclusion by Medicare.
20. Prescription drugs not listed on the formulary, unless you receive prior approval from the PBM.

**G. General Health Care Services Not Covered by HIRSP**

1. Health care services provided when your coverage was not effective under this policy. This includes health care services provided either prior to your effective date of coverage or after your coverage terminated under this policy.
2. Allowed amounts directly related to a HIRSP non-covered service. However, HIRSP covers medically necessary and appropriate treatment of a complication that resulted from a non-covered service if the treatment is a HIRSP covered service.
3. Health care services that HIRSP determines are experimental or investigative. (This does not include drugs for the treatment of HIV infection.) Please see definition of experimental or investigative in Section V.
4. Physical therapy, occupational therapy, and speech therapy services made available to treat learning disabilities in school-aged children. As provided under federal and state laws, services are available at no charge through the child's school district.
5. Health care services for treatment of an injury or illness that is payable under another policy of health care insurance, fixed indemnity, Medicare, or any other governmental program, except as otherwise provided by law. This exclusion does not apply to drug coverage for individuals who are also enrolled in the Wisconsin AIDS Drug Assistance Program and the Wisconsin Chronic Disease Program beginning with the seventh month of HIRSP eligibility.
6. Health care services for treatment of an injury or illness that is payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, liability insurance, or equivalent self-insurance policy.
7. Health care services for treatment of an injury or illness that is covered by workers' compensation or employers' liability laws.
8. Services for any injury or illness as the result of war, declared or undeclared, enemy action or action of armed forces of the United States, or any state of the United States, or its allies, or while serving in the armed forces of any country.
9. Personal comfort or convenience items, including, but not limited to, in-hospital television and telephone.
10. Health care services that are personal, are not medical, or do not require a physician's prescription.
11. Health care services whose provision is not within the scope of authorized practice of the institution or individual providing the services.
12. Custodial care

13. Charges for any missed appointment.
14. Administrative costs incurred in providing HIRSP with medical records to process claims, including, but not limited to, labor, taxes, shipping and handling, and photocopying expenses.
15. State tax on goods and services; shipping and handling.
16. Hospital and nursing home bed hold days.
17. Health care services provided by members of your immediate family or anyone else living with you.
18. Health care services performed by means of a telephone call between a physician and a policyholder, including those in which the physician provides advice or instructions to or on behalf of a policyholder, or between or among physicians on behalf of the policyholder.
19. Allowed amounts for, or in connection with, travel, except for ambulance transportation as specifically stated in Section IX. B. 3.
20. As separate charges, transportation expenses incurred by a physician, including, but not limited to, time and mileage.
21. Autopsies.
22. Health care services which aren't medically necessary for the treatment of an illness or injury, as determined by HIRSP.
23. Housekeeping, shopping, or meal preparation services.
24. Health care services provided during any waiting periods for pre-existing conditions.
25. Food received on an outpatient basis, food supplements, or vitamins, except as specifically stated in this policy.
26. Health care services provided in connection with: (a) any illness or injury caused by your engaging in an illegal occupation; (b) any illness or injury caused by your commission of, or an attempt to commit, a felony; or (c) any intentionally self-inflicted illness or injury, except an injury that resulted from an act of domestic violence or an illness. For example, an exclusion for self-inflicted injuries or injuries incurred in connection with a suicide attempt can not be applied to someone who attempts suicide if the injury is attributable to a medical condition (such as depression).
27. Maintenance care or supportive care.
28. That portion of the amount billed for a health care service covered under this policy that exceeds HIRSP's determination of the allowed amount for such health care service.
29. Health care services for which you have no obligation to pay.
30. Health care services for which proof of claim isn't provided to us in accordance with Section XII. B. Proof of Claim.
31. Health care services not for or related to an illness or injury, other than as specifically stated in the policy.
32. Wigs, prosthetic hair pieces, hair transplants, or hair implants.
33. Health care services not supported by information contained in your medical records from other relevant sources.

34. Health care services provided while held, detained or imprisoned in a local, state or federal penal or correctional institution, except as specifically stated in s. 609.65, Wisconsin Statutes. Persons on work release are not considered to be held, detained or imprisoned if they are otherwise eligible members.
35. Health care services provided for your convenience or for the convenience of a physician, hospital, or other health care provider.
36. Health care services not specifically identified as being covered under the policy.
37. Indirect services provided by health care providers for services such as, but not limited to: creation of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; and reviewing quality assurance data.
38. Nutritional counseling, except as specifically stated in this policy.

## **Section XII. General Provisions**

### **A. Subrogation**

You agree that HIRSP shall be subrogated to all of your rights to the extent of the benefits HIRSP provides under this policy. Those rights are hereby assigned to HIRSP to that extent. The assigned rights include, but are not limited to, rights against: (1) all persons or organizations, and their insurers, liable or responsible for paying for losses or damages you sustain; (2) automobile liability insurance coverage; (3) underinsured motorists insurance coverage; (4) uninsured motorists insurance coverage; (5) homeowner liability insurance coverage; (6) medical malpractice insurance coverage; (7) patient compensation funds; and (8) any applicable umbrella insurance coverage. The assigned rights shall not be reduced or diminished under any circumstances by attorney's fees, court costs or any other costs of collection which may be incurred by you.

HIRSP has no right to recover from you if you have not been made whole, after taking into consideration your comparative negligence. If a dispute arises between you and HIRSP over the question of whether or not you have been made whole, HIRSP has the right to a judicial and jury determination of whether you have been made whole. Such a determination shall be governed by the rules of evidence, shall require the fact finder to determine the dollar amount that makes you whole, and in all other substantive and procedural respects shall be conducted as is any other civil jury trial.

You shall promptly advise HIRSP in writing whenever a claim against any person and/or organization is made on your behalf and shall further provide to us such additional information as is reasonably requested by HIRSP. You agree to fully cooperate in protecting HIRSP'S rights against any person and/or organization. You shall not enter into a settlement or compromise arrangement with any person and/or organization without HIRSP'S prior written consent. Entering into any such settlement or arrangement is a breach of this contract; such a breach shall be deemed to prejudice HIRSP'S rights.

### **B. Proof of Claim**

HIRSP will pay benefits for covered services submitted on a properly completed, written proof of claim. You or the health care provider must file the claim with the Plan Administrator within 90 days following the date the covered services were provided. Written proof of your claim includes: (1) the completed claim forms if required by the Plan Administrator; (2) the actual itemized bill for each health care service; and (3) all other information that the Plan Administrator needs to determine HIRSP'S liability to pay benefits under this policy, including, but not limited to, medical records and reports. If circumstances prevent you or the health care provider from filing a claim within this time, HIRSP must receive the claim within 15 months following the date the services were provided. Under extraordinary circumstances, HIRSP may consider claims received after this deadline.

HIRSP will issue written notice regarding the claim within 30 days of receiving the claim, unless special circumstances require more time.

**C. Your Relationship with Your Physician, Hospital or Other Health Care Provider**

HIRSP won't interfere with the professional relationship you have with your physician, hospital or other health care provider. HIRSP does not contract with you to choose or provide a physician, hospital or other health care provider or services or facilities; nor does HIRSP assure their availability. HIRSP is not responsible for any injury, damage or expense (including attorneys' fees) you suffer as a result of any improper advice, action or omission on the part of any physician, hospital or other health care provider. HIRSP is obligated only to provide the benefits as specifically stated in this policy.

**D. Physician, Hospital or Other Health Care Provider Reports**

Physicians, hospitals and other health care providers must give the Plan Administrator their records and reports to help the Plan Administrator determine benefits due to you. By accepting coverage under this policy you agree to authorize your physicians, hospitals and other health care providers to release all medical records and reports to the Plan Administrator for yourself and all your dependents. This is a condition of HIRSP providing coverage to you and all your dependents. It's also a continuing condition of HIRSP paying benefits. You expressly authorize and direct the following to release these records and reports to Plan Administrator: (1) any physician who has diagnosed for, attended, treated, advised or provided professional services to you; (2) any hospital in which you were treated or diagnosed; and (3) any other health care provider who has diagnosed, attended, treated, advised or provided services to you. You authorize them to furnish to the Plan Administrator any and all information related to the health care services or facilities provided to or used by you, to the extent required by a particular situation and allowed by applicable law. You also expressly authorize the Plan Administrator to release to or obtain from any other insurance company or service or benefit plan the information which the Plan Administrator needs for it to determine HIRSP'S liability to pay benefits under this policy.

**E. Assignment of Benefits**

This coverage is just for you. Benefits may be assigned to the extent allowed by the Wisconsin insurance laws.

**F. Limitation on Lawsuits and Legal Proceedings**

No policyholder shall bring any legal action against HIRSP regarding benefits for claims submitted, to compel HIRSP payment of benefits, or any other matter concerning his/her coverage under this policy until the earlier of: (1) 60 days after the Plan Administrator has received or waived proof of claim described in subsection B. Proof of Claim; or (2) the date the Plan Administrator denies payment of benefits for a claim. Action can be brought earlier if waiting will result in prejudice against a policyholder. However, the mere fact that a policyholder has to wait until the earlier of the above is not considered prejudicial. No action can be brought more than three years after the time HIRSP requires written proof of claim. Please see subsection B. Proof of Claim.

**G. Severability**

Any term, condition or provision of the contract which may be prohibited by Wisconsin law shall be void and be without force or effect. But this won't invalidate the enforceability of any other term, condition or provision of the contract.

**H. Conformity With Laws of the State of Wisconsin**

On your effective date under this policy, any term, condition or provision conflicting with the laws of the State of Wisconsin applying to this policy automatically conforms with the minimum requirements of such laws.

**I. Entire Contract**

The entire contract between you and HIRSP is made up of this policy, all endorsements, if any, the customer's application, and his/her supplemental applications, if any.

**J. Waiver and Change**

Only HIRSP Authority can execute a waiver or make a change to this policy. No agent, broker or other person may waive or change any term, condition, exclusion, limitation, or other provision of this policy in any way or extend the time for any premium payment. At HIRSP Authority's option, it may unilaterally change any term, condition, exclusion, limitation, or other provision of this policy if written notice is sent to the policyholder at least 30 days in advance of that change. When the change reduces coverage provided under this policy, HIRSP Authority must send written notice of the change to the policyholder at least 60 days before any such change takes effect. Any change to this policy shall be made by endorsement which is signed by HIRSP Authority. Each endorsement shall be binding on each policyholder and HIRSP Authority. No error by HIRSP Authority or any policyholder shall invalidate coverage otherwise validly in force, continue or reissue coverage validly terminated, or cause coverage to be issued which otherwise would not be issued by HIRSP Authority. Upon HIRSP Authority's discovery of any error, an equitable adjustment of coverage, payment of benefits and/or premium shall be made by HIRSP Authority at its sole option.

**K. Limit on Certain Defenses**

After two years have passed from your effective date of coverage under this policy, no misstatement will be used to void your coverage or deny benefits for any claim beginning after the two-year period expires. This doesn't apply to fraudulent misstatements made in your application or any supplemental applications.

**L. Direct Payments and Recovery**

**1. Direct Payment of Benefits.**

Unless otherwise specifically stated in this policy, HIRSP has the option of paying benefits either directly to the physician, hospital or other health care provider, or to you as described below in subsection O. Claims Processing Procedure. Payments for covered expenses for which HIRSP is liable may be paid under another group or franchise plan or policy arranged through your employer, trustee, union or association. If so, HIRSP can discharge its liability by paying the organization that has made these payments. In either case, such payments shall fully discharge HIRSP from all further liability to the extent of benefits paid.

**2. Recovery of Excess Payments.**

If HIRSP pays more benefits than what it's liable to pay for under this policy, including, but not limited to, benefits paid in error by HIRSP, HIRSP can recover the excess benefit payments from any person, organization, physician, hospital or other health care provider that has received such excess benefit payments. HIRSP can also recover such excess benefit payments from any other insurance company, service plan or benefit plan that has received such excess benefit payments. If HIRSP cannot recover such excess benefit payments from any other source, HIRSP can also recover such excess benefits payments from you. When HIRSP requests that you pay HIRSP an amount of the excess benefit payments, you agree to pay HIRSP such amount immediately upon notification to you. HIRSP may, at its option, reduce any future benefit payments for which HIRSP is liable under this policy on other claims by the amount of the excess benefit payments, in order to recover such payments. HIRSP will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by HIRSP.

**M. Incontestability**

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

HIRSP shall not contest the validity of any policyholder's coverage under this policy after that person's coverage has been in force for two years from his/her effective date of coverage under this policy except for: (1) nonpayment of premium; or (2) a fraudulent statement contained in a document signed by that person or in an application or supplemental application, if any, for that person, a copy of which is supplied to the policyholder.

HIRSP shall not use a statement to reduce, limit or deny payment of benefits for a claim incurred by such policyholder after the expiration of such two-year period unless it is in a document signed by that person or, if that person is a dependent, in a document, application or supplemental application, if any, signed by the policyholder.

**N. Misstatement of Age**

Age means a policyholder's age on his/her last birthday. If a policyholder's age has been misstated, the premiums for that person's coverage shall be equitably adjusted as determined by HIRSP. If the amount of coverage and/or payment of benefits for the policyholder would be affected by such misstatement of age, the amount of coverage and/or payment of benefits shall be adjusted to that to which the policyholder would have been entitled at his/her correct age and the premium shall be adjusted on such adjusted amount of insurance.

**O. Claims Processing Procedure**

Benefits payable under this policy will be paid as soon as reasonably possible after the Plan Administrator receives the written proof of claim required to be submitted to the Plan Administrator by the policyholder in accordance with subsection B. Proof of Claim. The Plan Administrator will decide whether benefits are payable on the allowed amount for covered services submitted to us within a reasonable period of time after the Plan Administrator receives the written proof of claim described above in subsection B. Proof of Claim, which allows the Plan Administrator to make an informed decision as to whether benefits are payable. Any benefits paid in accordance with this policy shall fully discharge HIRSP from all further liability to the extent of benefits paid.

If benefits are payable on the allowed amount for services covered under this policy, the Plan Administrator will pay such benefits directly to the hospital, physician or other health care provider providing such services, unless you have already paid the allowed amount and submitted paid receipts therefore to the Plan Administrator before benefits are paid. The Plan Administrator will send you written notice of the benefits paid on your behalf. If you have already paid the allowed amount and are seeking reimbursement from HIRSP, payment of such benefits will be made directly to you.

If there are circumstances which require that the Plan Administrator have more time to determine HIRSP'S liability to pay benefits on such claim, the Plan Administrator will send you written notice within 30 days of the Plan Administrator's receipt of such proof of claim, explaining why the Plan Administrator needs more time to review the allowed amount. In that case, the Plan Administrator's decision on the claim will then be made within 120 days of receipt of such proof of claim.

If you want to appeal the denial, such an appeal must be made in accordance with subsection "P. Grievance Procedure" below.

If the claim is denied in whole or in part, you will receive a written notice from the Plan Administrator with (1) the specific reason(s) on which denial or partial denial is based; (2) the specific reference(s) to this policy provisions on which denial or partial denial is based; (3) a description of additional material or information which may be necessary for you to perfect your claim and an explanation of why such

material or information is necessary; and (4) an explanation of how you may have the claim reviewed by the Plan Administrator if you do not agree with our denial or partial denial. Please see subsection "P. Grievance Procedure" below.

**P. Grievance Procedure**

Situations might occasionally arise when you, as a policyholder, question or are unhappy with a claims decision made by the Plan Administrator or some aspect of the policy administration, claims processing, or service that you received from us. For example, you may question why the Plan Administrator made a claims decision or denied benefits for a claim submitted. Since most questions about the payment of benefits, claims processing decision, policy administration, or provision of service can usually be resolved without you having to file a grievance under this provision, we urge you first to try to resolve any problem, question, or concern that you have by directly contacting the Plan Administrator's Member Services Department.

Under this provision the policyholder has the right to file a written grievance with the Plan Administrator in accordance with the policyholder's grievance rights under Sections 632.853 and 632.855, Wisconsin Statutes, and Chapter 18, Wisconsin Administrative Code, as amended, respectively.

Sections 632.853 and 632.855, Wisconsin Statutes, apply to filing a grievance involving the Plan Administrator's denial of benefits or coverage for a claim, pre-authorization request, or other request for benefits or coverage submitted to us for a prescription legend drug, durable medical equipment or similar medical device, or an experimental treatment. Only the policyholder or his /her authorized representative can use this provision to exercise the policyholder's right to file a grievance, except as follows. Subject to Section 632.853, Wisconsin Statutes, as amended, the policyholder's physician may only use this provision to file a grievance on the policyholder's behalf with respect to the denial of benefits or coverage for a prescription legend drug or durable medical equipment or similar medical device.

The grievance procedure provided under this provision is intended solely to provide the policyholder with only the rights available to the policyholder, in accordance with these Wisconsin statutes and this administrative rule, to that extent these laws apply to the policyholder. This provision shall be applied and strictly construed by HIRSP in accordance with these laws.

But before filing a grievance under this provision, we urge the policyholder to first contact our Member Services Department to see if we can resolve the matter to your satisfaction. The first step toward resolving a problem, question, or concern is to bring this matter to our attention by telephoning our Member Services Department. Please see our telephone number shown on your HIRSP Identification Card. Our Member Services representative will take your information along with your proposed resolution and review the matter, including considering all information that they have available and the policy's applicable terms, conditions, and provisions. Our representative will then discuss the matter with the Supervisor of its Member Services Department.

If we agree with your proposed resolution of this matter, we'll tell you in writing by sending you either a letter or an Explanation of Benefits form explaining its subsequent claims processing action that resolves the matter. If, after receiving our response you are still unhappy with its subsequent claims processing action or administrative action that they believe resolves the matter as you proposed, you have the right to file a grievance in writing our Grievance/Appeal Committee in accordance with the procedure explained below.

If our Grievance/Appeal Department upholds our original decision which you questioned or with which you disagreed and if you had contacted us by writing a letter, then we will automatically forward this matter to our committee for its review and decision in accordance with the grievance procedure explained further below.

The grievance procedure differs depending upon the type of grievance that is filed with us. Paragraph 2. below describes the procedure that we use for handling grievances that are not "expedited grievances" as that term is defined below. Paragraph 3. below describes the procedure that we use for handling expedited grievances.

**1. Definitions.**

For the purpose of this subsection, the following terms shall mean:

**Authorized Representative:** a person a policyholder designates to file a grievance on his/her behalf and/or to act for him/her. By designating an authorized representative, this means that for purposes of the grievance, the policyholder is also authorizing us to treat that person as if he/she is the policyholder. The policyholder's designation also authorizes us to send that person, not the policyholder, our written decision responding to the grievance. Our committee's written decision will contain personal information about the policyholder, including his/her confidential medical information, if any, that applies to the matter which is being grieved.

**Expedited Grievance:** a grievance where any of the following applies:

- a. The duration of the standard resolution process will result in serious jeopardy to the life or health of the policyholder or the ability of the policyholder to regain maximum function.
- b. In the opinion of a physician with knowledge of the policyholder's medical condition, the policyholder is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
- c. A physician with knowledge of the policyholder's medical condition determines that the grievance shall be treated as an expedited grievance.

**Grievance:** any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, a policyholder.

**We, Us, Our:** the Plan Administrator.

**You, Your:** a policyholder, his/her authorized representative or his/her physician (if your physician submitted the grievance that pertains to our denial of benefits or coverage for a prescription legend drug or durable medical equipment or a similar medical device).

**2. Grievance Procedure For Grievances That Are Not Expedited Grievances (For Expedited Grievances, please see paragraph 3. below).**

- a. You have three years after you receive the initial notice of denial or partial denial of your claim to file a grievance. To file a grievance, you should write down the concerns, issues, and comments and mail, email, transmit by electronic facsimile (i.e. fax), or deliver the written grievance along with copies of any supporting documents to our Grievance Department at the address shown below. For example, if we denied benefits for your claim because we determined that a prescription legend drug, a durable medical equipment or medical device, or a treatment provided to you was not "medically necessary" and/or "experimental" as those terms are defined in this policy, please send us all additional medical information, including sending us copies of your health care provider(s)'s medical records, that you believe shows that the health care service was medically necessary and/or not experimental under the policy. Any grievance filed by the policyholder's physician regarding a prescription legend drug or a durable medical equipment or medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, or durable medical equipment or medical device that's not

covered under this policy. Please mail, email, fax, or deliver your written grievance to us at the following address:

HIRSP Grievance Department  
1751 West Broadway  
P. O. Box 7062  
Madison, Wisconsin 53707-7062  
Fax Number: (608) 223-3603  
Email Address: HIRSPweb@wpsic.com

We cannot accept telephone requests for a grievance. Your grievance must be in writing. Please deliver, fax, email, or mail your grievance to us at the address shown above.

- b.** We will acknowledge its receipt of your grievance by delivering, faxing, or mailing you an acknowledgment letter within five business days of its receipt of the grievance.
- c.** As soon as reasonably possible following our receipt of the grievance, our Grievance Department will review the grievance. Our Grievance Department will take the information along with your proposed resolution and review the matter, including considering all information that they have available and this policy's applicable terms, conditions, and provisions. If we agree with the proposed resolution of this matter, we will tell you in writing by sending you either a letter or an Explanation of Benefits form explaining its subsequent claims processing action or administrative action that resolves the matter to your satisfaction. If our Grievance Department upholds our original claims processing decision or administrative decision which was questioned or with which you disagreed, the grievance will be automatically forwarded to the Grievance Committee for its review and decision in accordance with the grievance procedure explained further below. Under no circumstances will the time frame exceed the time stated in paragraphs e. and f. below.
- d.** You have a right to appear in person or to participate by teleconference before the Grievance Committee which meets at our offices in Madison, Wisconsin, to present written or oral information to the committee and to submit written questions to the person(s) responsible for making the determination which resulted in the grievance. In the committee's written decision to the grievance the committee will respond to all of the written questions submitted to the committee prior to or at that meeting. The committee will notify you in writing of the time and place of the meeting at least seven calendar days before the meeting. Please remember that this meeting is not a trial where there are rules of evidence that are followed. Also, cross-examination of the committee's members, its advisors, or Plan Administrator's employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the committee. The person's presentation to the committee may be tape-recorded by the committee. If you attend the meeting to present the reason(s) for the grievance, we expect and require each person who attends the meeting to follow and abide by the internal practices, rules and requirements established by the committee to handle grievances effectively and efficiently in accordance with the applicable laws.
- e.** Within 30 days after our receipt of the grievance, the Grievance Committee will send you its written decision by letter which will contain the specific reasons for its decision, identify the specific terms, conditions, and/or provisions of this policy, if any, on which the decision is based, and what action, if any, has been taken by us to resolve this matter. Our committee's letter will be sent to the person who filed the grievance by regular mail using the United States Postal Service unless that person's grievance asked the committee to transmit its written decision by electronic facsimile (i.e. fax) to that person.

- f. While reviewing your grievance the committee may need additional time to make its decision. In that case, before the 30-day period mentioned in paragraph e. above has expired, the committee will send you a written notice by letter that the committee needs an extension of time to complete its review of the grievance and make its decision, how much additional time the committee needs, and when the committee's decision is expected to be made, and the reason additional time is needed. The committee then has an additional 30 days after the first 30-day period has expired (or within 60 days from the date they first received the grievance) to \*provide you with its written decision. We are precluded by law from delaying our committee's decision beyond that 60-day period even if you request a delay beyond the end of this 60-day period.
- g. We will retain our records of the grievance for at least three years after we send you the committee's letter providing written notification of its decision.

**3. Grievance Procedure For Grievances That Are Expedited Grievances (For Grievances that are not Expedited Grievances, please see paragraph 2. above).**

- a. Please see the definition of the term "expedited grievance" that's defined in paragraph 1. above. Only an expedited grievance that meets that definition's requirements will be handled by us under this provision. If the request isn't an expedited grievance as that term is defined, please use the grievance procedure set forth in paragraph 2. above.

To file an expedited grievance, you must call the telephone number shown below to give us the concerns, issues, and comments underlying your grievance, or write down the concerns, issues, and comments and mail, email, transmit by electronic facsimile (i.e. fax), or deliver the written grievance along with copies of any supporting documents to our Grievance Committee at the address shown below. For example, if we denied benefits for your claim because we determined that a prescription legend drug, a durable medical equipment or medical device, or a treatment provided to you was not "medically necessary" and/or "experimental" as those terms are defined in this policy, please send us all additional medical information, including sending us copies of your health care provider(s)'s medical records, that you believe shows that the health care service was medically necessary and/or not experimental under this policy. Any grievance filed by your physician regarding a prescription legend drug or durable medical equipment or a medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, or durable medical equipment or medical device that's not covered under this policy.

HIRSP Grievance Committee

**Expedited Grievance**

1751 West Broadway

P.O. Box 7062

Madison, Wisconsin 53707-7062

Phone: (608) 221-7128 or toll-free 1-800-828-4777, extension 17128

Fax Number: (608) 223-3603

Email Address: [HIRSPweb@wpsic.com](mailto:HIRSPweb@wpsic.com)

- b. As soon as reasonably possible following our receipt of the expedited grievance, our Grievance Department will review the expedited grievance. Our Grievance Department will take the information along with your proposed resolution and review the matter, including considering all information that we have available and this policy's applicable terms, conditions, and provisions. If we agree with the proposed resolution of this matter, we will tell you in writing by sending you either a letter or an Explanation of Benefits form explaining its subsequent claims processing action or administrative action that resolves the matter to your satisfaction. If our Grievance Department upholds our

original claims processing decision or administrative decision which was questioned or with which you disagreed, the grievance will be automatically forwarded to our Grievance Committee for its review and decision in accordance with the grievance procedure explained below. Under no circumstances will the time frame exceed the time stated in paragraph c. below.

- c. As expeditiously as your health condition requires, but not later than 72 hours after our receipt of the expedited grievance, the Grievance Committee will send you its written decision by letter which will contain the specific reasons for its decision, identify the specific terms, conditions, and/or provisions of this policy, if any, on which the decision is based, and what action, if any, that has been taken by us to resolve this matter. Our committee's letter will be sent to the person who filed the expedited grievance by regular mail using the United States Postal Service unless that person's expedited grievance asked the committee to transmit its written decision by electronic facsimile (i.e. fax) to that person.
- d. We will retain its record of the grievance for at least three years after we send you the committee's letter providing written notification of its decision.

#### 4. **Review by HIRSP Appeal Committee**

If you disagree with our decision on the review as described in 2. or 3. above, you may file an appeal with the HIRSP Appeal Committee within 30 days of receiving our decision as described above. To file an appeal, you must submit a written request including pertinent information such as name, identification number, date and place of service, and reason for the appeal.

**Clearly indicate that the written request is an appeal.** This will help the HIRSP Appeal Committee process the request.

Mail, fax, or email appeals to:

HIRSP Appeal Committee  
33 East Main Street  
Suite 230  
Madison, Wisconsin 53703  
Fax Number: 608-441-5776  
Email Address: [info@hirsp.org](mailto:info@hirsp.org)

Upon receiving the request, the HIRSP Appeal Committee will review the Grievance Committee decision and either affirm, modify, or rescind it. The HIRSP Appeal Committee will communicate its decision, and the reason for the decision, in a written response within 45 days from the receipt of the request for review.

#### **Q. Your Right to Have an Independent Review Organization (IRO) Review Your Dispute**

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

Only disputes that involve medical judgment can be decided through independent review. You can request an independent review if you were denied coverage for a health care service because the Plan Administrator has determined that the health care service is not medically necessary, experimental or investigative or if you disagree with our determination regarding the diagnosis and level of service for treatment of autism. In addition, the total cost of the denied coverage must exceed the amount specified in s. 632.835, Wisconsin Statutes, as amended. The health care service must be a covered benefit under this policy; benefits specifically excluded from this policy are not eligible for independent review. Pursuant to Wisconsin Statute 632.835(3) (f), as amended, a decision of an IRO is binding on the insured

and the insurer, subject to their respective rights under Wisconsin law to appeal that decision to a court of competent jurisdiction.

To request an independent review, you will need to complete this policy's grievance and review procedure, except as specifically stated otherwise in this subsection. You must wait for the determination on your grievance before you can submit your request for independent review. You may send a written request for independent review to the following address:

Wisconsin Physicians Service Insurance Corporation  
Attention: IRO Coordinator  
P.O. Box 7458  
Madison, WI 53708

You must submit your request for an independent review within four consecutive months after receiving notice of the disposition of your grievance and such request must include:

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

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

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

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

The IRO rights described in this subsection are available only to the extent that HIRSP is required to provide those rights under Section 632.835, Wisconsin Statutes, as amended, and Chapter Ins 18, Wis. Adm. Code, as amended. Nothing in this subsection provides, or shall be interpreted or construed to provide, any IRO right or rights in excess of, or in addition to, the IRO rights required to be provided by

HIRSP under Section 632.835, Wisconsin Statutes, as amended, and Chapter Ins 18, Wis. Adm. Code, as amended.

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

**R. Grace Period**

Except for the first premium, any premium not paid to HIRSP by the first date of the renewal period is in default. For each premium not paid when due, there is a grace period of 31 days beginning with the first day of the renewal period during which you must pay the premium unless you've notified HIRSP in advance that you want to terminate this policy. This policy's coverage is in force during the grace period. If you don't pay your premium within the grace period, this policy shall automatically terminate on the last day of the grace period. You still must pay for coverage provided during that grace period.

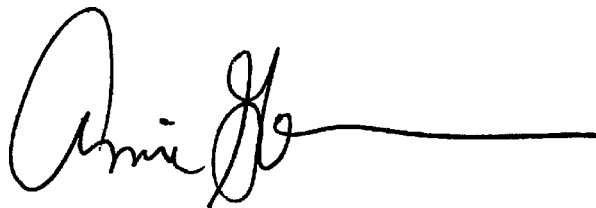
**S. Reinstatement**

HIRSP does not provide for the reinstatement of this policy if it lapses due to nonpayment of the premium. If the policyholder mails or delivers a premium to HIRSP after the grace period, HIRSP will return the premium as soon as HIRSP determines the premium is late and may reduce that payment by any claims paid during the grace period. No agent is authorized by HIRSP to accept a late premium.

**T. Physical Examinations**

HIRSP, at its expense, has the right to have the policyholder examined when and as often as is reasonable during the processing of a claim.

**This policy is signed for HIRSP by**

A handwritten signature in black ink, appearing to read "Amie Goldman", followed by a long horizontal line extending to the right.

**Amie Goldman**

**CEO, Health Insurance Risk-Sharing Plan Authority**