



**Physicians Plus**  
INSURANCE CORPORATION

22 E. Mifflin Street, Suite 200  
Madison, WI 53703

www.pplusic.com  
email: ppinfo@pplusic.com

(800) 545-5015  
(608) 282-8900

---

## Medical Certificate of Coverage

As a Member of Physicians Plus, You are responsible for understanding the benefits to which You are entitled under this Policy, and the rules You must follow to receive those benefits.

Benefits are outlined in this Medical Certificate of Coverage and the appropriate Schedule of Benefits.

# TABLE OF CONTENTS

---

IMPORTANT INFORMATION .....	1
WELCOME TO PHYSICIANS PLUS INSURANCE CORPORATION .....	2
MEMBER RIGHTS AND RESPONSIBILITIES .....	3
IMPORTANT PHONE NUMBERS AND ADDRESSES .....	4
1. GENERAL GUIDELINES .....	5
2. DEDUCTIBLE, COINSURANCE, COPAYMENTS AND MAXIMUMS .....	7
3. EMERGENCY AND IMMEDIATE/URGENT MEDICAL CARE .....	8
4. BENEFITS AND SERVICES .....	10
Anesthesia Services .....	10
Ambulance Services .....	10
Autism Services .....	10
Behavioral Health and Alcohol and Other Drug Abuse (AODA) Services .....	11
Childhood Immunizations .....	13
Chiropractic Services .....	13
Dental/TMD & Oral Surgery .....	14
Detoxification Services .....	15
Diagnostic Services .....	15
Facility and Hospital Services/Skilled Nursing Facilities .....	15
Hearing Aids .....	17
Immediate/Urgent Care .....	17
Infertility/Conception & Reproductive Services .....	18
Insulin and Disposable Diabetic Supplies .....	18
Kidney Disease/Transplant .....	19
Lead Poisoning .....	19
Maternity Services .....	19
Medical Services .....	20
Medical Supplies, Durable Medical Equipment & Prostheses .....	20
Phase II/Outpatient Cardiac Rehabilitation .....	21

Physical, Speech, Occupational and Rehabilitative Therapy .....	21
Drug, Outpatient .....	22
Radiation Therapy .....	24
Surgical Services .....	24
Termination of Pregnancy .....	25
Transplants .....	25
Vision Services .....	27
5. GENERAL POLICY EXCLUSIONS AND LIMITATIONS .....	27
6. EFFECTIVE DATES AND ELIGIBILITY .....	29
7. OTHER POLICY PROVISIONS .....	32
8. COORDINATION OF BENEFITS .....	38
9. DISENROLLMENT AND WHEN COVERAGE ENDS .....	41
10. CONTINUATION OF COVERAGE .....	43
11. EXTENSION OF BENEFITS .....	46
12. APPEAL PROCESS .....	46
13. PRIVACY AND CONFIDENTIALITY .....	50
14. DEFINITIONS .....	50

# IMPORTANT INFORMATION

The Medical Certificate of Coverage is a description of health insurance benefits provided to Physicians Plus Insurance Corporation Members.

This is an out standard HMO Policy and requires You to obtain services from a Participating Provider, except in the case of certain Emergency and Urgent Care situations (PLEASE READ THE EMERGENCY AND URGENT CARE SECTION IN THIS CERTIFICATE) or if your employer has purchased a POS or PPO plan that allows you to see a non participating provider (see amendment if applicable).

When You obtain covered services from a Physicians Plus Participating Provider, charges will be paid based on the terms, conditions, limitations and benefits of Your Policy and the contract between Physicians Plus and the Participating Provider. If there is a difference in the amount paid by Physicians Plus and the amount billed by the Participating Provider for covered services, You are not responsible for that difference (other than for applicable deductibles, coinsurance and other benefit limits).

When prior authorized by Physicians Plus, covered services received from a Non-Participating Provider may be covered up to the Usual and Customary charge (subject to applicable Deductibles, Coinsurance and other benefit limits). The Usual and Customary charge may be less than the amount billed by the Provider of services. Please refer to section 14. DEFINITIONS of this certificate for the definition of Usual and Customary.

If You have any questions please contact Our Member Service department at (608) 282-8900 or (800) 545-5015.

# WELCOME TO PHYSICIANS PLUS INSURANCE CORPORATION

---

It is Your responsibility to know Your benefits. Please carefully read the information provided in this Medical Certificate, Schedule of Benefits and any riders and/or amendments that may apply to Your Plan. This is the Medical Certificate used by Physicians Plus to administer benefits and process claims.

Please ALWAYS keep these **KEY POINTS** in mind:

1. **This is an HMO Policy. YOU MUST SEEK SERVICES WITH A PARTICIPATING PROVIDER.**

Some Providers may practice at more than one clinic. Please refer to the index of the Provider Directory for a listing of participating Providers and locations. Providers are only covered at the locations listed in the Provider Directory. Our Provider Directory is available on our website at [www.pplusic.com](http://www.pplusic.com)

2. **Always consult with Your Primary Care Physician (PCP)** for all Your primary and specialty care needs.
3. If You are seeing a Provider other than Your PCP, prior authorization may be required. **Please talk with Your PCP to obtain prior authorization when needed.**
4. **You may change Your PCP** at any time by calling Our Member Service department at (608) 282-8900 or (800) 545-5015 or visit Our website at [www.pplusic.com](http://www.pplusic.com). The change will be effective on the first of the month following Our notification of the change.
5. **ALL inpatient care including hospitalizations, hospital rehabilitation, hospice care and skilled nursing facilities require PRIOR AUTHORIZATION before services are provided.** If You do not obtain Prior Authorization when required, services will not be covered. Please contact Our Member Service department if You have questions regarding Our Prior Authorization requirements.

**Meriter Hospital and the University of Wisconsin Hospitals and Clinics (UWHC) are the participating hospitals in the Madison area.**

**Planned hospital admissions at non-participating Hospitals WILL NOT be authorized.** Non-participating hospitals include, but are not limited to, Mayo Clinic and Hospitals, St. Mary's Hospital (Madison) and Mercy Hospital in Janesville, and/or any other non-participating hospital.

6. **If You have questions about Your Policy or coverage please contact Our Member Service department** at (608) 282-8900 or (800) 545-5015 or visit Our website at [www.pplusic.com](http://www.pplusic.com).
7. **PLEASE IMMEDIATELY READ THE EMERGENCY AND IMMEDIATE/URGENT MEDICAL CARE SECTION OF THIS CERTIFICATE.**

## MEMBER RIGHTS AND RESPONSIBILITIES

---

Physicians Plus is committed to maintaining a mutually respectful relationship with Members and at the same time We expect Members to assume certain responsibilities. Your rights and responsibilities are described below.

You have the right to:

- Receive clear and accurate information about Physicians Plus and Your Policy benefits, Your rights and responsibilities, information about all services offered and how and when You can use such services;
- Receive information (name, address, phone number) about participating Providers, hospitals, pharmacies and other health care Providers available to You;
- Be treated with dignity and respect and to have Your personal health information kept private, secure and confidential;
- Participate with physicians and other health care professionals in the decision-making process regarding Your health care;
- Candidly discuss appropriate and medically necessary treatment options for Your condition(s), regardless of the cost of the benefit and/or coverage;
- Request and receive information about Advance Directives;
- Be informed about preventative health services including self care and how to stay healthy;
- Voice complaints or appeals about Physicians Plus or the care provided to You.

Each Member has the following responsibilities:

- Read and understand materials made available by Physicians Plus concerning Your health Plan benefits and coverage. Plan information is available online and/or in the Medical Certificate of Coverage, Schedule of Benefits, Amendments/Riders and Member Handbook;
- Build a relationship with Your primary care physician and keep Your appointments or provide proper notice if You must cancel with any Provider;
- Provide information that Physicians Plus and Providers need in order to care for You;
- Provide accurate and correct health insurance policy information and arrange to pay for Deductibles, Coinsurance, Copayments and non-covered services if You are billed;
- Ask questions about Your Illness or Injury, Your treatment plan and how to manage Your health;
- Follow the plans and instructions for care that You and Your physician agree on;
- Treat health Plan and health care Providers, employees and other patients with respect and display proper behavior for the health care setting.

# IMPORTANT PHONE NUMBERS AND ADDRESSES

---

**Physicians Plus Insurance Corporation**

**WEBSITE** [www.pplusic.com](http://www.pplusic.com)

## GO-TO

Access Your healthcare information, claims and authorizations, change Your PCP and more with GO-TO Our 24/7, free, secure, and easy to use online resource. GO-TO Our website at [www.pplusic.com](http://www.pplusic.com) for more GO-TO information.



### HEALTH CARE ADVICE ANYTIME !

#### Physicians Plus NursePlus Nurse Line

Available 24/7. Call one of the nurses toll free at 866-PPLUSRN or (866) 775-8776

#### Member Services *Benefit/Claim Status, Prior Authorization and General Questions*

Phone: (608) 282-8900 or (800) 545-5015

TDD: (608) 260-7998

Fax: (608) 258-1902

E-Mail: [ppicinfo@pplusic.com](mailto:ppicinfo@pplusic.com)



#### Behavioral Health and/or Alcohol or Drug Abuse:

For Prior Authorization please contact

UW Behavioral Health Case Management and Consultation Services at:

Phone: (608) 282-8960 or (800) 683-2300

## R<sub>x</sub>

#### Pharmacy Services

Phone: (608) 260-7803 or (800) 545-5015

Fax: (608) 258-1905

#### Claims: PHYSICIANS PLUS Mailing Addresses

##### Medical Claims

Physicians Plus Insurance Corporation

P.O. Box 269017

Plano, TX 75026



##### Chiropractic Claims:

ChiroTech America, Inc.

NI4 W23833 Stone Ridge Drive, Suite 330

Waukesha, WI 53188

If You have prescription drug coverage with Physicians Plus, please mail pharmacy claims to:

Physicians Plus Insurance Corporation

Attention: Pharmacy Services

P.O. Box 2078

Madison, WI 53701-2078

# I. GENERAL GUIDELINES

---

This Medical Certificate offers a general description of Your health insurance benefits. Please see the DEFINITIONS section of this Certificate for capitalized terms.

The Policy is issued by Physicians Plus Insurance Corporation (Physicians Plus) and delivered to the Policyholder in the state of Wisconsin. The laws of the state of Wisconsin govern all terms, conditions and provisions of the Policy. All benefits are provided in accordance with the terms, conditions and provisions of the Policy and applicable Wisconsin laws. All benefits described are subject to the terms of the Policy. The Policy alone is the agreement under which payments are made. The Policy may be changed or canceled, according to its terms, without Your consent. ***As a Physicians Plus Member, You are responsible for understanding the benefits to which You are entitled under the Policy and the rules You must follow to receive those benefits.***

This Certificate replaces and supersedes any other certificate, which may have been previously issued.

**COVERAGE:** This Policy was not priced or designed to cover every Illness or Injury You and/or Your dependents may encounter while insured by this Policy; this Policy provides coverage for only treatment, services and supplies that you receive during the Contract Year and that are identified as "Physicians Plus will cover". You must obtain services from a Physicians Plus Participating Provider. If You are not sure of Your coverage or Your level of benefits, please contact the Physicians Plus Member Service department at (608) 282-8900 or (800) 545-5015.

**COVERAGE LIMITATIONS:** Physicians Plus will cover benefits and services listed in this Certificate for Members covered by this Policy. You must obtain services from a Physicians Plus Participating Provider. Exclusions and limitations that apply to this Policy are listed throughout the BENEFITS AND SERVICES section of this Certificate as well as in the GENERAL POLICY EXCLUSIONS AND LIMITATIONS and DEDUCTIBLE, COINSURANCE, COPAYMENTS AND MAXIMUMS sections of this Certificate. In some instances the Group Master Policy may specify a benefit period that is different than a Calendar Year. In those situations, benefit limits will be applied based on the special benefit period rather than the Calendar Year. Please consult your employer's Group Master Policy. Your Schedule of Benefits also may list exclusions and limitations that apply. Please read the sections mentioned above for complete coverage guidelines.

**ID CARD:** Please use Your Physicians Plus identification card each time You or any of Your covered dependents obtain services from a Physician, Hospital, facility, clinic, pharmacy (if You have prescription drug coverage with Physicians Plus) or any other health care Provider. Receipt of an ID Card does not guarantee coverage. Coverage is based on eligibility and benefits at the time services are rendered.

**YOUR PCP:** All Members of Physicians Plus must choose a Primary Care Physician (PCP) who will coordinate Your care. Physicians Plus will pay for Medically Indicated covered benefits and services according to the terms of this Policy when ordered by Your PCP and/or performed by a Participating Provider at a Participating Facility.

**PRE-EXISTING CONDITION LIMITATION:** Pre-existing condition limitations do not apply to Physicians Plus Commercial HMO policies. Pre-existing DOES APPLY to some individual plans and all POS and PPO plans.

**PRIOR AUTHORIZATION:** Some services obtained from a Provider other than Your PCP require written approval by Physicians Plus **before** services are provided. Your PCP will fill out the information needed on the Prior Authorization form and then send it to Physicians Plus for approval. Physicians Plus will send a letter to You and Your Provider when a decision is made whether to approve or deny the Prior Authorization. Coverage is based on eligibility and benefits at the time services are rendered. If a Prior Authorization is required but not obtained, Physicians Plus will not pay for the treatment(s), services or supplies provided. (See the GENERAL POLICY EXCLUSIONS AND LIMITATIONS section of this Certificate).

The following services **DO NOT** require Prior Authorization when a **Participating Provider** provides the services:

- Routine office visits;
- Specialty care;
- Services from a **Participating** Immediate/Urgent Medical Care center in the Physicians Plus Service Area;
- Emergency Medical Care obtained from a **Participating** Provider at a Participating Facility;
- Emergency Medical Care when the Member is outside of the Physicians Plus Service Area. You must contact Physicians Plus within 48 hours of care;
- Chiropractic care (Long Term Care/Therapy and/or Long Term Maintenance Care/Therapy is not covered);
- Routine eye exam and refraction (one exam and refraction per Member per Contract Year);
- Routine hearing exam (one exam per Member per Contract Year);
- Obstetric and gynecological services performed by a **Participating** OB/GYN or a licensed nurse practitioner within the scope of the nurse's license.
- Dental care (if Your Policy includes dental care): You must obtain services from a **Participating** dentist.
- RENTED Medical Supplies: Including diabetes supplies, Durable Medical Equipment and supplies.

The following are *examples* of services that **DO require Prior Authorization** approved in writing by Physicians Plus **prior** to obtaining services. This is NOT an all-inclusive list:

- Services not listed above;
- All treatment, services and supplies being requested and/or performed by any **NON-Participating Provider**, including but not limited to Physicians, clinics, Hospitals and pharmacies;
- All care (other than Emergency Medical Care) received out of the Service Area;
- All Hospital admissions and/or inpatient care;
- Outpatient/Ambulatory surgeries/services/procedures that may be considered cosmetic (not a covered benefit), including but not limited to, reduction mammoplasties, blepharoplasties and septo-rhinoplasties;
- Dental care that requires treatment, services or supplies at an outpatient Hospital or Ambulatory Surgery Center;
- Medical Supplies: Including diabetes supplies, Durable Medical Equipment, supplies and Prosthetic Device purchased over \$5000;
- Home care services, supplies and therapies;
- Hospice care;
- Skilled nursing care;
- Transplants (All);
- Behavioral Health (nervous or mental illness) and Alcohol or Drug Abuse (AODA) (chemical dependency) services. To obtain Prior Authorization and/or find a Participating Provider, contact the Behavioral Health Case Management and Consultation Services at (608) 282-8960 or (800) 683-2300.

**PROVIDER DIRECTORY:** The Physicians Plus Provider Directory provides the names, locations and phone numbers of all Participating Providers associated with Physicians Plus. This directory is current as of the date it is printed. Included in Your Member information is a Provider directory or post card that explains how to obtain an additional Provider Directory. You also can find the most current updated list of Physicians Plus Participating Providers on Our website at [www.pplusic.com](http://www.pplusic.com)

Some Providers may practice at more than one clinic. Please refer to the index of the Provider Directory to see all locations listings. Providers are considered Participating Providers **ONLY** at the locations listed in the Provider Directory.

Physicians Plus does not have contracts with out of network providers and therefore has no control over documentation, costs, billing and/or coding practices and/or the quality of treatments, services and supplies provided by a out of network provider.

## **2. DEDUCTIBLE, COINSURANCE, COPAYMENTS AND MAXIMUMS**

---

Deductibles, Coinsurance, Copayments and/or Maximums are calculated on a Contract Year basis and will be applied to services as shown in Your Schedule of Benefits. When the applicable Deductible, Copayment, Coinsurance and/or out-of-pocket maximums (if any) shown in the Schedule of Benefits is met, benefits for services are payable at the applicable level also shown in the Schedule of Benefits up to the limits of the Policy. No benefits are payable for the expenses used to satisfy a Member's Deductible, Coinsurance, Copayments or out-of-pocket maximum. The Member is responsible for paying the expenses used to satisfy the Deductible, Coinsurance, Copayment and/or out-of-pocket maximums.

In some instances the Group Master Policy may specify a benefit period that is different than a Contract Year. In those situations, benefit limits will be applied based on the special benefit period rather than the Contract Year. Please consult your employer's Group Master Policy.

### **CALCULATION OF DEDUCTIBLE, COINSURANCE and MAXIMUMS**

Some of Our contracts with health care Providers may entitle Physicians Plus to discounts, allowances, adjustments and/or settlements. In other situations, We have contracted to pay Providers on a basis that is not tied to the services that the Provider actually renders to Physicians Plus Members. For example, some Providers may be paid based on the number of Physicians Plus Members that select or are assigned to the Provider. In other cases, the Provider may be paid based on a percentage of Physicians Plus' premiums. When a Physicians Plus Member receives services from any such Provider, any Coinsurance, Deductible and/or out-of-pocket limits owed by the Member and any Lifetime Benefit Maximum or other benefit maximum may be calculated by Physicians Plus on the basis of the Provider's Billed Charges. Any discounts, allowances, adjustments, settlements, refunds or other savings that are realized by Physicians Plus will be for the sole benefit of Physicians Plus.

### **DEDUCTIBLE**

The Deductible is a specific dollar amount that is shown in the Schedule of Benefits that the Member is responsible to pay. There may be an annual Policy Deductible that applies to all treatments, services and supplies that the Member (or the Member's family, in the case of Family Coverage) must pay in a Contract Year before benefits are payable under this Policy. There also may be Deductible for particular treatments, services or supplies that the Member also must pay before any benefits are payable under this Policy for that treatment, service or supply.

### **OUT-OF-POCKET LIMITS**

The Schedule of Benefits shows the maximum out-of-pocket amounts for both Single Coverage and Family Coverage that a Member (or the Member's family, in the case of Family Coverage) may be obligated to pay in each Contract Year. The Schedule of Benefits also shows which out-of-pocket expenses (Deductible, Coinsurance and for some policies, Copayments) that accumulate toward the out-of-pocket limit. Amounts in excess of Covered Charges (other than Deductible, Coinsurance and for some policies, Copayments) do not accumulate toward the out-of-pocket limit. After the applicable Contract Year out-of-pocket limit is satisfied, Physicians Plus will pay benefits at 100% of Covered Charges incurred by a Member during the remainder of the Contract Year subject to any other limitations and the terms and conditions of the Policy.

There also may be a maximum out-of-pocket amount for particular treatments, services and/or supplies that the Member may be obligated to pay. Any such limits are also shown in the Schedule of Benefits.

### **BENEFIT MAXIMUMS**

The Policy's Schedule of Benefits may establish Lifetime Maximum Benefit limits for all or some benefits. Any such maximum limits the aggregate benefits (medical and prescription drug (if applicable)) that You may receive under this Policy, all renewals of this Policy and all other policies that are consecutively issued by Physicians Plus to the Policyholder prior to and after this Policy.

The Schedule of Benefits also may establish Benefit Maximums that limit the benefits that You may receive under this Policy for particular treatments, services and supplies.

### 3. EMERGENCY AND IMMEDIATE/URGENT MEDICAL CARE

---

#### **EMERGENCY and IMMEDIATE/URGENT MEDICAL CARE in and out of the Physicians Plus Service Area**

**Emergency Medical Care** means Medical Services provided to a Member by a Physician or other medical professional licensed by the state in which the care is provided in connection with an Emergency Medical Condition.

*As defined by Wisconsin Statute 632.85 "Emergency Medical Condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, 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:*

- (1) Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;*
- (2) Serious impairment to the person's bodily functions; or*
- (3) Serious dysfunction of one or more of the person's body organs or parts.*

Emergency Medical Care does not include non-emergency or urgent care, routine health, dental care or maintenance treatment, services and supplies and/or routine medical exams.

MERITER HOSPITAL AND THE UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS ARE THE PARTICIPATING FACILITIES IN THE MADISON AREA.

MERITER HOSPITAL IS THE PREFERRED PARTICIPATING HOSPITAL IN THE MADISON AREA FOR MEMBERS OF PHYSICIANS PLUS AND MEMBERS ON A MERITER CHOICE REWARD PLAN.

ST. MARY'S HOSPITAL MADISON AND ST. MARY'S EMERGENCY FACILITY IN SUN-PRAIRIE ARE NOT PARTICIPATING FACILITIES FOR PHYSICIANS PLUS. PLEASE SEE YOUR PROVIDER DIRECTORY FOR A COMPLETE LIST OF PARTICIPATING FACILITIES IN YOUR AREA.

Treatment and services provided in any Hospital emergency room must meet the definition of "Emergency Medical Condition"(see definition above). If services are provided in a Hospital emergency room that do not meet the definition of Emergency Medical Care, coverage for the services will be denied and You will be responsible for the payment of all charges. All benefits are determined at the time of claim.

**If You require Emergency Medical Care and You are in the Physicians Plus Service Area**, You should go to a Participating Hospital emergency room for services when You can safely do so. If You cannot safely travel to a Participating Hospital and there is a closer Non-Participating Hospital, You should go to that closer Hospital emergency room for assistance and notify Physicians Plus within 48 hours or as soon as medically possible. If You are admitted to either a participating Hospital or Non-Participating Hospital, You and/or the Hospital must notify Physicians Plus within 48 hours of the admission or as soon as medically possible.

**If You are out of the Physicians Plus Service Area** and require Emergency Medical Care and cannot safely return to the Service Area to receive that care, You should go to the closest Hospital emergency room and notify Physicians Plus within 48 hours or as soon as medically possible. If You are admitted to the Non-Participating Hospital, You and/or the Hospital must notify Us within 48 hours or as soon as medically possible.

Once You are stable, Physicians Plus will seek to have You transferred to a Participating Hospital in Our Service Area. If You are not transferred to a Participating Hospital, Physicians Plus will coordinate Your care with the Hospital and Physicians.

Physicians Plus does not have contracts with out of network providers and therefore has no control over costs, billing and/or coding practices and/or the quality of treatments, services and supplies provided by a out of network provider.

All Physicians Plus polices include an emergency room Copayment and/or Deductible and Coinsurance. Please read Your Schedule of Benefits carefully to determine the applicable Copayment and/or Deductible and/or Coinsurance that may apply. Deductibles, Coinsurance, Copayments and maximums on any Physicians Plus Policy are cost sharing mechanisms. Cost sharing mechanisms are not penalties for obtaining services.

Physicians Plus will waive the emergency room (ER) copayment ONLY when the patient is admitted to the Hospital within 24 hours for the same Illness or Injury treated in the emergency room. In some cases, a patient may be in an observation bed. This is NOT an admission and is not billed as an Inpatient Admission and/or stay. Observation is normally billed by the Hospital as an ER visit. If so, the Copayment is not waived.

**Immediate/Urgent Medical Care:** If You require Immediate/Urgent Medical care and are not able to wait until You can see Your PCP You should:

- (1) CONTACT YOUR PCP: Your PCP will direct You to the most appropriate immediate care facility available; or
- (2) CONTACT NursePlus at (866) 775-8776 or (866) PPLUSRN; or
- (3) SEEK IMMEDIATE/URGENT CARE: Go to a Immediate/Urgent Medical Care center that is a Participating Provider.

If You are out of the Service Area and require Immediate/Urgent medical care services, follow the instructions 1- 2 above. If You are instructed by Your PCP or the NursePlus line to seek services from a Non-Participating facility for Immediate/Urgent or Emergency Care, please contact Physicians Plus within 48 hours to report that You received services from a Non-Participating Provider. Physicians Plus will determine benefits at the time of claim.

**Non-Emergency and Non-Immediate/Urgent Care While Out of the Service Area:** Any medical care when You are out of the Service Area must be Prior Authorized *except for* (a) Emergency Medical Care (b) Immediate/Urgent Medical Care and (c) those services for an Eligible Dependent Student described immediately below.

Any medical care that can be safely postponed until you return to the Service Area will not be Prior Authorized for coverage out of the service area. If follow up care is Prior Authorized and Medically Indicated, We will cover 50% of follow up care up to the Usual and Customary Charge for covered treatment, services or supplies. Physicians Plus will determine benefits, including whether the medical care is Medically Indicated, at the time a claim is made.

**Outpatient Behavioral Health and chemical dependency services for Eligible Dependent students out of the Service Area:** Physicians Plus will cover services for Prior Authorized Outpatient Behavioral Health and AODA services out of the Service Area for a dependent, if the dependent is a qualified full-time student attending school and living in Wisconsin but out of the Physicians Plus Service Area.

- The qualified dependent may have a clinical assessment by a Non-Participating Provider that Physicians Plus designates. If outpatient services are Medically Indicated, Physicians Plus will cover 5 outpatient visits. All visits must be Prior Authorized by Physicians Plus.
- If the dependent is unable to maintain full-time student status, the dependent must return to the Physicians Plus Service Area for treatment with a Participating Provider.
- Physicians Plus will determine benefits at the time of claim.

Physicians Plus will not cover any treatment, services or supplies received that are not Medically Indicated as determined by Physicians Plus; or that are not authorized by Physicians Plus. Any follow-up care received at a Non-Participating Hospital or Physician after the emergency service is not a covered benefit, unless Prior Authorized by Physicians Plus.

## 4. BENEFITS AND SERVICES

---

**THE FOLLOWING PROVISIONS APPLY TO ALL BENEFITS AND SERVICES OF THIS POLICY:**

### **This is an HMO Plan - ALL SERVICES MUST BE OBTAINED FROM A PARTICIPATING PROVIDER.**

This Policy was not priced nor designed to cover every illness or injury you and/or your dependents may encounter while on this Policy; this Policy provides coverage for only the benefits identified as “Physicians Plus will cover” in this Policy, and all benefits are subject to exclusions and limitations. Benefits are determined at the time of claim. If you are not sure of your coverage or the level of benefits, please contact the Physicians Plus Member Service department at (608) 282-8900 or (800) 545-5015 or [ppinfo@pplusic.com](mailto:ppinfo@pplusic.com).

Physicians Plus will cover benefits and services listed in this Policy with the following limitations (please also see the GENERAL POLICY EXCLUSIONS AND LIMITATIONS section of this Certificate):

- You must be an Eligible Employee or Eligible Dependent and be enrolled under this Policy; and
- Deductibles, Coinsurance, Copayments and maximums and/or benefit and lifetime limitations may apply (refer to Your Schedule of Benefits); and
- All services must be performed by a Participating Provider; and
- Services not specifically listed in this Policy are not covered under this Policy; and
- Any service that is not Medically Indicated, as determined by Physicians Plus, is not a covered benefit under this Policy; and
- Some services not performed by Your Primary Care Physician (PCP) require Prior Authorization from Physicians Plus before obtaining services. Services obtained without the proper Prior Authorization will not be covered by this Policy.

### **ANESTHESIA SERVICES**

Physicians Plus will cover anesthesia services appropriately provided in connection with other covered services. Physicians Plus will not cover anesthesia services provided in connection with any services not covered by this Policy.

### **AMBULANCE SERVICES**

Physicians Plus will cover ground and air ambulance services when it is determined to be emergent and medical attention is required en route to a medical facility. All air ambulance services will be subject to a maximum benefit of \$25,000 per occurrence.

Physicians Plus will not cover non-emergency ground and air ambulance services or services that are not emergency transportation and medical attention is not required en route to a medical facility unless Prior Authorization was given by Physicians Plus.

### **AUTISM**

This benefit information is subject to change pending regulatory clarification by the State of Wisconsin and/or other applicable regulatory agencies. The Wisconsin State Budget mandates coverage for evidence based therapy for members with a verified diagnosis of Autism Spectrum Disorder. Coverage must be provided for member up to \$50,000 for intensive level services per insured per year if services begin between the ages of 2-9 with at least 20 hours of care per week for up to 4 cumulative years; and \$25,000 for non-intensive services per member per year. These monetary amounts will be adjusted annually beginning in 2011. Coverage will be subject to Deductibles, Coinsurance and Copayments that generally apply to other conditions covered by the plan. Coverage may not be subject to limitations on the number of treatments. See the following page for details.

**Autism Spectrum Disorder** means:

1. Autism;
2. Asperger's syndrome; or
3. Pervasive spectrum disorder not otherwise specified.

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

**Non-Intense Level Therapy** means 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.

**COVERAGE:** This policy will provide coverage for a primary verified diagnosis of Autism Spectrum Disorder as defined above. Physicians Plus reserves the right to require a second opinion diagnosis with a participating provider.

1. \*All intensive services require prior authorization (HMO, POS, PPO):
  - a. Prior Authorization can be obtained by calling the Behavioral Health Case Management and Consultation Services at (608) 282-8960 or (800) 683-2300.
  - b. Treatment plans and assessments will be required minimally every 6 months.
2. Coverage is subject to Deductibles, Coinsurance and Copays.
  - a. Copays will apply for office visits. Applicable Deductibles and Coinsurance will apply based on policy provision and how services are billed by the provider.
3. HMO members are required to seek services with a participating provider;
4. PPO and POS members may seek services with a non-participating provider; off panel cost-sharing will apply; all intensive services require prior authorization\*;
5. The policy will provide intensive-level behavioral therapy (see definition above) per member per year for up to \$50,000. Therapy must be based on a treatment plan for at least 20 hours per week for up to a total of 4 years (this includes services provided prior to coverage under this policy).
6. The policy will also provide up to \$25,000 (adjusted annually by the Department of Labor's Consumer Price Index beginning in 2011) per member per year for Non-Intensive Level Therapy (see definition above);

\*Obtaining Prior Authorization is not a guarantee of benefits. Physicians Plus will determine Your benefits based on Your available coverage at the time services were provided. Claims will be processed and apply to any applicable limits in the order they are received. Prior Authorization can be obtained for all types of service by calling the Behavioral Health Case Management and Consultation Services at (608) 282-8960 or (800) 683-2300.

Physicians Plus will not cover the following services: Travel for parents, providers therapists or paraprofessionals; Fraudulent Claims; Acupuncture; Animal-based therapy including horse- therapy; Auditory integration training; Chelation therapy; Child care fees; Cranial sacral therapy; Custodial or respite care/therapy; Hyperbaric oxygen therapy; Special diets or supplements; Parent Training Program.

This information is subject to change please contact Physicians Plus for additional information.

## **BEHAVIORAL HEALTH AND ALCOHOL AND OTHER DRUG ABUSE (AODA) SERVICES**

Please read Your Schedule of Benefits for dollar and/or visit limitations that may apply. Except as stated below for dependent students and court-ordered services, all Behavioral Health and AODA Services must be obtained by a Participating Provider that is a licensed behavioral health clinician. All services require Prior Authorization. Obtaining Prior Authorization is not a guarantee of benefits. Physicians Plus will determine Your benefits based on Your available coverage at the time services were provided. Claims will be processed and apply to any applicable limits in the order they are received.

Prior Authorization can be obtained for all types of service by calling the Behavioral Health Case Management and Consultation Services at (608) 282-8960 or (800) 683-2300.

Physicians Plus will cover the following Behavioral Health and AODA Services, subject to the limitations in Your Schedule of Benefits, the COVERAGE LIMITATIONS stated below, and the other terms and conditions of the Policy:

- Inpatient Behavioral Health or AODA Services: Medically Indicated services for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems that are provided to a Member who is a bed patient in a Participating Provider that is any of the following:
  - (A) a Hospital licensed under s. 50.35 of the Wisconsin Statutes;
  - (B) an approved private treatment facility as defined under s. 51.45(2)(b) of the Wisconsin Statutes; or
  - (C) an approved public treatment facility as defined in s. 51.45(2)(c) of the Wisconsin Statutes.
- Outpatient Behavioral Health or AODA Services: Medically Indicated nonresidential services for the treatment of nervous and mental disorders or alcoholism and other drug abuse (AODA) problems that are provided to a Member and, if for the purpose of enhancing the treatment of the Member, to a member of his/her Immediate Family, by a Participating Provider that is any of the following:
  - (A) a program in an outpatient treatment facility, if both are approved by the Department of Health Services ("DHS"), the program is established and maintained according to rules promulgated under s. 51.42 (7) (b) of the Wisconsin Statutes and the facility is certified under s. 51.04 of the Wisconsin Statutes;
  - (B) a licensed Physician, who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office;
  - (C) a licensed psychologist who is listed in the National Register of Health Service Providers in psychology;
  - (D) a licensed psychologist who is certified by the American Board of Professional Psychology; or
  - (E) a state certified masters-level clinician such as a clinical social worker or marriage and family therapist.
- Transitional Treatment Services: Medically Indicated services for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems that are:
  - (A) Behavioral Health services for adults provided in a day treatment program that is offered by a Participating Provider and that is certified by DHS under Wisconsin regulation s. HFS 61.75;
  - (B) Behavioral Health services for children and adolescents provided in a day treatment program that is offered by a Participating Provider and that is certified by DHS under Wisconsin regulation s. HFS 40.04;
  - (C) Services for persons with chronic mental illness provided through a community support program of a Participating Provider and that is certified by DHS under Wisconsin regulation s. HFS 63.03;
  - (D) A residential treatment program for alcohol or drug dependent persons, or both, that is provided by a Participating Provider and that is certified by DHS under Wisconsin regulation s. HFS 75.14 (1) and (2);
  - (E) Services for alcoholism and other drug problems provided in a day treatment program of a Participating Provider and that is certified by DHS under Wisconsin regulation s. HFS 75.12 (1) and (2); or
  - (F) Intensive outpatient programs for the treatment of psychoactive substance use disorders provided by a Participating Provider in accordance with the patient placement criteria of the American Society of Addiction Medicine.

Services from Non-Participating Providers. Physicians Plus will cover only the following Behavioral Health and AODA Services that are provided by a Non-Participating Provider:

- Services for Dependent Students: Physicians Plus will cover the following Outpatient Behavioral Health and AODA Services that are provided out of the Service Area if Prior Authorized and provided to a Member who is an Eligible Dependent student attending school and living in Wisconsin but out of the Physicians Plus Service Area:
- The dependent student may have a clinical assessment by a Non-Participating Provider that Physicians Plus designates.
- If outpatient services are Medically Indicated, Physicians Plus will cover 5 outpatient visits. All visits must be Prior Authorized by Physicians Plus.

If the dependent student is unable to maintain Full-Time Student status, the dependent must return to the Physicians Plus Service Area for treatment with a Participating Provider. Physicians Plus will determine benefits at the time of claim. Physicians Plus will not cover any treatment, services or supplies that are not Medically Indicated, as determined by Physicians Plus, or that are not Prior Authorized by Physicians Plus.

- Court-Ordered Services: Physicians Plus will cover court-ordered services for the mentally ill as required by Section 609.65 of the Wisconsin Statutes.

#### COVERAGE LIMITATIONS:

- Behavioral Health and AODA days/visits are limited as indicated in the appropriate Schedule of Benefits;
- Family counseling is a covered therapy only when the Member, who is receiving the Behavioral Health or AODA Services, is present for the counseling sessions.

The cost of diagnostic testing and/or imaging and prescription drugs related to Behavioral Health and AODA are not applied to BH/AODA benefit maximum limitations if applicable.

Physicians Plus will not cover: Non-traditional therapy including but not limited to: animal therapy; dance therapy; art therapy; video therapy; hypnotherapy; marriage counseling; family counseling (except as described in the last bullet point, above); residential care (except as described under transitional Treatment Services, above); halfway houses (except as described under Transitional Treatment Services, above); biofeedback; Long-Term or Maintenance Care/Therapy; gambling addiction; nicotine dependency (diagnosis code 305.1); caffeine intoxication (diagnosis code 305.90); learning disabilities (diagnosis codes 315.00 - 315.80); mental retardation (diagnosis codes 317.00-319.00); all Behavioral Health diagnosis V-Codes such as marital problems and academic problems.

#### CHILDHOOD IMMUNIZATIONS

Physicians Plus will cover early childhood immunizations for children when services are provided by a Participating Provider.

Physicians Plus will not cover immunizations not Medically Indicated, as determined by Physicians Plus, and services provided by a Non-Participating Provider.

#### CHIROPRACTIC SERVICES

Physicians Plus will cover Medically Indicated chiropractic services when the services are provided by a Participating Provider practicing within the scope of his/her chiropractic license.

Physicians Plus will not cover: chiropractic services performed by a Non-Participating Provider; services that are not within the scope of the chiropractor's license; Long Term and/or Maintenance Care/Therapy services as determined by Physicians Plus; and services not Medically Indicated as determined by Physicians Plus.

## **DENTAL/TMD & ORAL SURGERY**

Also refer to Your dental Policy for general dental coverage, if applicable.

**-ACCIDENTAL DENTAL:** Physicians Plus will cover the following dental services that are provided by the appropriate provider and are required to treat sound natural teeth that are injured while you are covered under this Policy.

1. The term "injured" does not include conditions resulting from eating, chewing or biting.
2. Treatment must begin within 90 days after the initial date of injury; or as soon as medically appropriate.
3. Tooth extractions and replacement with artificial teeth, because of an accidental injury.

**-HOSPITAL AND AMBULATORY SURGERY CENTER CHARGES:** Physicians Plus will cover facility and ambulatory surgery center charges and anesthesia for dental care provided in a Participating Hospital/Facility and/or Ambulatory Surgery Center if the Member: is a child under the age of 5 years; or has a Chronic Disability; or has a medical condition that requires hospitalization and/or general anesthesia for dental care. All services must be Prior Authorized.

**-TMD:** Physicians Plus will cover diagnostic services and Medically Indicated surgical and non-surgical treatment (including intraoral splint therapy devices) for the correction of temporomandibular disorders (TMD) if all of the following apply:

- A congenital, developmental or acquired deformity, disease or Injury caused the condition; and
- The service or device is reasonable and appropriate for the diagnosis or treatment of this condition as determined by Physicians Plus; and
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Coverage for diagnostic procedures and non-surgical procedures is limited to \$1250 per Member per Contract Year.

A Participating Provider designated to treat TMD must provide the services for all TMD services including intraoral splint therapy devices. The splint therapy device is considered Durable Medical Equipment (DME) and requires Prior Authorization if the cost is over \$5000.

**-ORAL SURGERY:** Physicians Plus will cover only the services listed below. A participating oral surgeon must perform all services. Covered services include any x-rays and anesthesia related to the listed oral surgery services only:

- The initial consultation with a participating oral surgeon;
- Removal of third molars (wisdom teeth);
- Removal of impacted teeth;
- Incision or excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Apicoectomy (excision of the apex of the tooth root);
- Excision of exostosis (bony-outgrowth) of the jaws and hard palate for the purpose of constructing dentures;
- External incision and drainage of cellulitis of the mouth;
- Incision of accessory sinuses; incision or excision of salivary glands or ducts;
- Residual root removal;
- Alveolectomy (the leveling of structures supporting the teeth for the purpose of fitting dentures), if not performed in connection with the extraction of natural teeth;
- Root amputation;
- Treatment of fractures of facial bones;
- Surgical exposure of teeth for orthodontic purposes (bonding and bracketing are excluded);
- Intraoral incision, drainage or biopsies.

Physicians Plus will not cover: treatment, services and supplies not listed above or not otherwise specifically covered in this Policy; dental services performed by a Non-Participating Provider; dental services performed in an emergency room. Other non-covered conditions and services include but are not limited to dental treatment, services and supplies such as: bridges; crowns or caps; dental implants; or jaw adjustments; surgery or orthodontia to correct malocclusion, including when related to or Injury conditions resulting from damage due to eating, chewing or biting Injury; treatment, services and supplies, including any ancillary Medical Services or supplies related to a non-covered benefit and/or periodontal/inflammatory gum disease; oral surgery except as listed in the oral surgery benefits.

## **DETOXIFICATION SERVICES**

Physicians Plus will cover Medically Indicated inpatient and outpatient detoxification services when performed by an approved Provider and Prior Authorization is approved by Physicians Plus.

Detoxification counseling services will be applied to Your Behavioral Health and Alcohol and Other Drug Abuse (AODA) benefits as determined by Physicians Plus. Physicians Plus will determine when detoxification services are medical in nature and when they will apply to Behavioral Health and AODA Services.

Physicians Plus will not cover: services that are not Medically Indicated as determined by Physicians Plus; or services not authorized by Physicians Plus; services for which Physicians Plus is not responsible for payment; Physicians Plus will not cover as detoxification services listed and/or covered by another benefit listed in this Certificate. Please also refer to the Behavioral Health and AODA Services section of this Certificate.

## **DIAGNOSTIC SERVICES**

Physicians Plus will cover x-ray and lab tests for the treatment and diagnosis of a covered Illness or Injury including: physical exam; CT and PET scans; MRA/MRIs; Sleep Studies; routine mammography; blood tests to detect lead exposure in children under 6 years old. Some procedures may be diagnostic and/or therapeutic and will be subject to any applicable Deductible, Coinsurance, Copayments and Benefit and Lifetime maximums on Your Policy.

Physicians Plus will not cover any x-ray or lab services in conjunction with: a service that is not covered under this Policy; any services not Medically Indicated as determined by Physicians Plus; any form of paternity testing; hair analysis (unless lead or arsenic poisoning is suspected); cytotoxic testing in conjunction with allergy testing.

## **FACILITY AND HOSPITAL SERVICES/SKILLED NURSING FACILITIES**

Physicians Plus will cover inpatient and outpatient care, as described below, when Medically Indicated for the diagnosis and treatment of an Illness or Injury. Treatment and services can be diagnostic or therapeutic and will be subject to any applicable Deductible, Coinsurance, Copayments and maximums.

Covered services also include drugs and medications a Member receives while confined in the Hospital, or in an inpatient medical facility (this does not include take home or Outpatient Prescription Drugs; see PRESCRIPTION DRUG, OUTPATIENT section if applicable).

Physicians Plus will not cover: any care that is not Medically Indicated; cosmetic procedures/services, as determined by Physicians Plus; or treatment, services and supplies that required Prior Authorization, but for which Prior Authorization was not obtained from or approved by Physicians Plus prior to services being rendered; take home drugs and supplies; any services listed as not covered in this Policy whether the service or procedure is performed as an inpatient or outpatient service.

**-INPATIENT CARE:** Physicians Plus will cover inpatient services for Medically Indicated care, subject to any Deductible, Coinsurance, Copayments and maximums that may apply as outlined in Your Schedule of Benefits. All inpatient care must be Prior Authorized by Physicians Plus.

Covered services include: charges for a semi-private (or lesser) room and board; incremental nursing services; Miscellaneous Hospital Expenses; intensive care room and board; inpatient physical, speech and occupational therapy; inpatient medications; inpatient lab services and x-rays.

Confinement means the period starting with a Member's admission on an inpatient basis to a hospital or other facility for the treatment of an illness or injury and ending with the Member's discharge from the same facility. However, if the Member is transferred and/or admitted to another facility for continued treatment of the same or related illness or injury, within 60 days, it will be considered one Confinement.

Benefits for rehabilitative Confinements are limited to 90 days per condition per Contract Year.

Physicians Plus will not cover:

- (A) Any care not Medically Indicated, as determined by Physicians Plus;
- (B) Any services not authorized and/or approved by Physicians Plus;
- (C) Take home drugs dispensed at the time of Hospital discharge, unless a written prescription is obtained and filled at a participating pharmacy as part of an outpatient prescription drug benefit (if any);
- (D) DME and/or Medical Supplies billed and available over the counter or not purchased from a participating DME vendor;
- (E) Hospital stays that are extended for reasons other than medical necessity (lack of caregiver, lack of transportation etc.);
- (F) Hospital days when a patient is out on a pass (unnecessary charges/room and board);
- (G) Respite care;
- (H) Private duty nursing care;
- (I) Coma therapy care; coma rehabilitation therapy;
- (J) Any continuous Hospital stay when care can be provided in a less Acute care setting;
- (K) Hospitalization and inpatient services, prescriptions, supplies and equipment for the treatment of obesity or morbid obesity, including but not limited to gastric and intestinal bypasses, gastric balloons, stomach stapling, wiring of the jaw and weight loss programs, even if You have other health conditions that might be helped by the reduction of weight;
- (L) Personal comfort or convenience items such as in Hospital television, telephone, private rooms, housekeeping and homemaker services, and meal services as part of home health care.
- (M) Any services related to sex transformation.
- (N) Services and treatment for a re-admission for the same illness or injury if the patient/member discharged themselves and/or left the hospital against medical advice as determined by the Physician and Physicians Plus.

**-OUTPATIENT CARE:** Physicians Plus will cover Prior Authorized Medically Indicated outpatient services for: diagnostic testing; laboratory testing; or Surgical Services at a Participating Hospital or ambulatory care facility that is a Participating Facility.

Physicians Plus will not cover: any treatment or services that are not Medically Indicated; services not Prior Authorized; procedures and supplies related to sex transformations; reversal of sterilization and related procedures; cosmetic procedures/services, as determined by Physicians Plus; keratorefractive eye surgery and related medications, including but not limited to radial keratotomy; DME and/or Medical Supplies available over the counter.

**-SKILLED NURSING FACILITY/SWING BED:** Physicians Plus will cover Skilled Nursing Care as determined by Physicians Plus. Benefits are limited to the number of days outlined in Your Schedule of Benefits. The Member must be admitted to a Physicians Plus-approved skilled nursing facility within 24 hours of discharge from a Hospital for continued treatment of the same condition that required inpatient Hospital care. All skilled nursing facility care must be Prior Authorized by Physicians Plus.

Confinement means the period starting with a Member's admission on an inpatient basis to a Hospital or other facility for treatment of an illness or injury and ending with the Member's discharge from the same facility. However, if the Member is transferred and/or admitted to another facility for continued treatment of the same or related illness or injury, within 60 days, it will be considered one Confinement.

Covered services include: charges for a semi-private (or lesser) room and board; incremental nursing services; Miscellaneous Hospital Expenses; intensive care room and board; inpatient physical, speech and occupational therapy; inpatient medications; inpatient lab services and x-rays.

Physicians Plus will not cover: any services that are not Medically Indicated, services related to Custodial, intermediate, intermittent/part time home nursing care; maintenance or domiciliary care; any nursing services not determined by Physicians Plus to be Skilled Care; private duty nursing care; community and/or government health re-entry programs; Respite Care; facilities and charges related to Rest Care; any charges related to care that is not approved by Physicians Plus.

**-HOME CARE SERVICES:** Physicians Plus must prior authorize all home care services. Physicians Plus will cover home care authorized by Physicians Plus as Skilled Nursing Care when provided by a participating registered or practical nurse. A home care treatment plan must be set up by the Attending Physician and reviewed and approved by Physicians Plus. The Attending Physician must review the treatment plan at least every two months. Home care may also include physical, occupational, respiratory and speech therapies. Treatment for these therapies must be part of the home care plan and will apply toward the Member's therapy benefits as outlined in the Schedule of Benefits.

Physicians Plus will not cover private duty nursing care. Home care is not covered unless the Attending Physician certifies that: hospitalization or Confinement in a skilled nursing facility will be necessary if home care was not provided; the Member's Immediate Family or others living with the Member cannot provide the needed care and treatment without undue hardship as determined by Physicians Plus; and a state licensed or Medicare-certified home health agency or certified rehabilitation agency will provide or coordinate the home care. Home care must be Prior Authorized by Physicians Plus.

**-HOSPICE CARE:** Physicians Plus will cover hospice care due to an Illness or Injury when: the Member has a life expectancy of 6 months or less; care is provided by a licensed hospice care provider that is a Participating Provider; and the hospice care has been Prior Authorized by Physicians Plus.

Physicians Plus will not cover Respite Care; Rest Care; private duty nursing care; care for services related to a family Member not on the Policy; services not Prior Authorized by Physicians Plus.

## HEARING AIDS

Physicians Plus will cover one hearing aid per ear replaceable every 36 months up to the amount shown in Your Schedule of Benefits (0-18 one standard model per ear; 18+ one hearing aid up to \$400 per ear, replaceable every 36 months), Coinsurance does not apply to any maximum out of pocket. Hearing aids must be purchased through a Participating Provider. Please refer to the SURGICAL SERVICES section for information on cochlear implants.

Physicians Plus will not cover cosmetic hearing aids, as determined by Physicians Plus; masking and/or hearing devices not meeting the above criteria for hearing aids.

## IMMEDIATE/URGENT CARE

Please read the EMERGENCY AND IMMEDIATE/URGENT MEDICAL CARE section of this Certificate for more information.

If You require Immediate/Urgent Medical Care and are not able to wait until You can see Your PCP, You should:

1. CONTACT YOUR PCP: Your PCP will direct You to the most appropriate immediate care facility available;
2. CONTACT NursePlus at 866-775-8776 or 866-PPLUSRN; or
3. SEEK IMMEDIATE/URGENT CARE: Go to a immediate care center in Your area that is a participating provider or facility. Please refer to Your Physicians Plus Provider directory for a immediate care center in Your area.

If You are out of the Service Area and require Immediate/Urgent Medical Care services follow instructions 1-2 above. If You are sent to a Non-Participating Facility for Immediate/Urgent Medical Care, please contact Physicians Plus within 48 hours to report that You received services from a Non-Participating Provider. Services are determined at the time of claim.

Physicians Plus does not have contracts with out of network providers and therefore has no control over costs, billing and/or coding practices and/or the quality of treatments, services and supplies provided by an out of network provider.

## **INFERTILITY/CONCEPTION AND REPRODUCTIVE SERVICES**

Physicians Plus will cover only those infertility/conception and reproductive services outlined in this Policy, up to the benefit limits listed in Your Schedule of Benefits. A Participating Provider must provide all services. All services provided after the maximum dollar limit has been covered by Physicians Plus are the Member's responsibility. Infertility Treatment or Recurrent Miscarriage care services are limited to one diagnostic and treatment course per Member per lifetime; all services are subject to the Lifetime Maximum Benefit outlined in Your Schedule of Benefits. Physicians Plus will cover approved infertility drugs up to the limits of the Policy when prescription drug coverage and infertility/conception and reproduction services coverage is in place with Physicians Plus. Family planning and infertility/conception services are limited to techniques and procedures for evaluation and treatment that are considered to be medically appropriate by Physicians Plus.

Physicians Plus will not cover any infertility conception services if the benefit is NOT listed on Your Schedule of Benefits and this Medical Certificate, including but not limited to: artificial insemination; amniocentesis or chorionic villi sampling (CVS) solely for sex determination; consultation or services in connection with invitro fertilization, embryo transplantation and/or any other reproductive technique such as GIFT or ZIFT; hormone therapy or drugs; invitro fertilization; embryo transfer; freezing or storage of embryo, eggs or semen, reversal of sterilization or related procedures; donor sperm or related services and procedures; sperm enhancement services; any services related to surrogate mother services.

## **INSULIN AND DISPOSABLE DIABETIC SUPPLIES**

Physicians Plus will cover: Formulary insulin and diabetes supplies when purchased from a Participating Provider or pharmacy that is a Participating Facility; and Physicians Plus-approved diabetes self-management and educational programs at a Participating Provider or Participating Facility.

Covered Disposable Supplies include blood or glucose strips, control solutions for monitors, alcohol wipes/swabs, cotton balls/swabs, finger stick devices, lancets and syringes, lancet pens, urine reagent strips.

Formulary insulin and diabetes supplies and services are subject to any Deductible, Coinsurance, Copayments and maximums as outlined in Your Schedule of Benefits.

Supplies and Formulary insulin are dispensed in a 30-day supply quantity. Infusion pumps and blood glucose monitors are subject to the Durable Medical Equipment and/or supply Coinsurance outlined in Your Schedule of Benefits. Insulin infusion pumps are limited to the purchase of one pump per Contract Year. A patient must use the pump for at least 30 days before the pump is purchased.

Physicians Plus will not cover non-Formulary insulin; replacement of insulin due to accident, damage, theft or abuse; damaged supplies due to misuse of equipment; and services and supplies not listed above.

Any form of insulin supplies and infusion devices not identified above, will not be covered unless it is determined to be Medically Indicated by Physicians Plus and Prior Authorized by Physicians Plus.

## **KIDNEY (RENAL) DISEASE/TRANSPLANT**

Physicians Plus will cover up to \$30,000 per Member per Contract Year for inpatient and outpatient treatment of end-stage renal disease and/or kidney disease treatment, including: inpatient and outpatient kidney dialysis; organ procurement; kidney transplantation and all related Medical Services of both receiver and donor when Prior Authorized by Physicians Plus.

Physicians Plus will cover services only if the recipient of the kidney and treatment is a Physicians Plus Member. The covered donor-related charges are those charges related to the person actually donating the kidney.

Physicians Plus is not required to duplicate coverage that is available to You under Medicare or any other insurance coverage You may have.

## **LEAD POISONING**

Physicians Plus will cover diagnostic blood lead tests for children under the age of 6 years.

## **MATERNITY SERVICES**

All Maternity related services are subject to the appropriate Policy Deductible, Coinsurance, Copayments and maximums identified in Your Schedule of Benefits.

Multiple services delivered during Your pregnancy may be billed by Your Provider as one global code. The global billing may cover both outpatient services (prenatal and/or postnatal care) and inpatient delivery services. This is the standard billing practice established by the Department of Health and Human Services for Physicians and other health care professionals. When outpatient services are included in the global billing code, along with inpatient services, Deductibles and Copayments will be calculated based on Your inpatient benefits.

Physicians Plus will cover Medically Indicated Maternity Services for: prenatal and postnatal care provided in a hospital and/or a office visit setting (when billed separately and not part of a global code, the office visit Copayment is waived for normal and high risk office visits for Maternity Care); normal deliveries; ectopic pregnancies; Medically Indicated cesarean sections; anesthesia; and miscarriages.

Physicians Plus will not cover: services that are not Medically Indicated; cesarean sections that are not Medically Indicated; inpatient services requiring Prior Authorization that were not Prior Authorized by Physicians Plus; labor and delivery services outside of the Service Area or any services with a non-Participating Provider, Clinic, Hospital or Facility; Clinic, Hospital or Facility charges or services after the 34th week of pregnancy; services provided in a stand alone birth or birthing center (this does NOT include birthing centers at a hospital/facility); termination of pregnancy when it does not meet the Physicians Plus criteria as outlined in this Policy; any services related to surrogate mother services.

### **STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996:**

Inpatient care for the insured mother and the insured newborn child will be covered for at least 48 hours following a vaginal delivery and at least 96 hours following a cesarean section. However, federal law does not prohibit the mother's or the newborn's attending Provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

**PRIOR AUTHORIZATIONS:** No Prior Authorization is required for the Hospital length of stay required by the Newborns' and Mothers' Health Protection Act of 1996 when the hospitalization is with a Participating Hospital. We do, however, ask that You contact Our Member Service department prior to Your hospitalization so that We can monitor and coordinate Your care and to help You enroll Your newborn. **PRIOR AUTHORIZATION IS REQUIRED** for any portion of a Hospital stay after the 48 hours (or 96 hours in the case of a cesarean section) and for ANY inpatient services from a Non-Participating Provider.

**NEW MEMBERS ONLY:** When Prior Authorized, Physicians Plus will cover care from a Non-Participating Physician for Maternity care to NEW Physicians Plus Members that are in their 3rd trimester at the time of enrollment.

All services **MUST** be Prior Authorized by Physicians Plus before ANY services are rendered. Newborn treatment, services and supplies must be provided by a Participating Provider.

## **MEDICAL SERVICES**

Physicians Plus will cover Medically Indicated, as determined by Physicians Plus, Medical Services and/or supplies as listed in this Medical Certificate and Your Schedule of Benefits.

Refer to Your Medical Certificate and Schedule of Benefits for specific coverage information. In general, Medically Indicated covered Medical Services include but are not limited to the following services performed by a Participating Provider:

- Medical exam;
- Immunizations;
- IV Therapy;
- Eye exam;
- Hearing exam;
- Routine physical;
- Routine mammograms;
- Medically indicated podiatry care;
- A second opinion from a Participating Provider;
- Growth hormone therapy, when the patient meets Physicians Plus criteria for coverage and the therapy is Prior Authorized by Physicians Plus;

Physicians Plus will not cover services listed in the GENERAL EXCLUSIONS AND LIMITATIONS section of this Medical Certificate.

## **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND PROSTHESES**

Prior authorization is required for all purchases of Medical Supplies, Durable Medical Equipment and Prostheses (Prosthetic Device) that exceed \$5000.

Physicians Plus will cover Medical Supplies, Durable Medical Equipment and Prostheses up to the limits of the Policy when: prescribed by a Participating Provider and purchased from a Participating Provider for the treatment of an Illness or Injury (a Participating Pharmacy Provider is not a Participating Medical Supplies or Durable Medical Equipment Provider or vendor for Medical Supplies, Durable Medical Equipment and Prostheses).

**LIMITATIONS:** Supplies and equipment are limited to the standard model as determined by Physicians Plus; standard model electric scooters are covered when Physicians Plus criteria is met.

Coverage for consumable supplies is limited to a 30-day supply or period of use; coverage for compression stockings is limited to 2 pair per Member per Contract Year; post mastectomy bra and custom made Prostheses is limited to 2 per Member per Contract Year; shoe lift limited to 2 per Member per Contract Year; other limitations may apply.

All supplies and/or equipment are subject to any Deductible, Coinsurance, Copayments and maximums outlined in Your Schedule of Benefits.

Some examples of Medical Supplies, Durable Medical Equipment and Prostheses are (this is **not** an all inclusive list of covered equipment and supplies):

- Artificial limbs
- Prostheses
- Orthotics
- Breast Prostheses

- Oxygen supplies
- TENS units
- Splints, crutches and braces
- Hospital beds
- Respiratory/Respiration equipment
- Wheelchairs
- Leg Brace
- Compression Stockings (limited to 2 pair per Member per Contract Year).

Physicians Plus will not cover any of the following services, supplies, equipment or Prostheses:

- Services, supplies and/or equipment not Medically Indicated;
- Services, supplies and/or equipment purchased through a pharmacy or non-Participating Provider/vendor;
- Repairs and replacement of equipment and supplies unless Prior Authorized by Physicians Plus;
- Lost or stolen supplies and/or equipment;
- Disposable and/or over-the-counter supplies and/or equipment including but are not limited to: adult diapers (and related supplies), gauze bandages, incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical face masks and irrigating kits;
- Supplies and equipment purchased at a Pharmacy Provider;
- Routine periodic maintenance and/or battery replacements;
- Medical Supplies and Durable Medical Equipment for comfort or personal hygiene and convenience, including but not limited to: air cleaners, air conditioners, humidifiers, physical fitness equipment, Physician's equipment, tanning beds, whirlpools, swimming pools, hot tubs, sauna's, Disposable Supplies, self help devices and equipment not medical in nature;
- Eye glasses, lenses or frames and fittings, except as specifically listed in this Policy;
- Home testing devices and monitoring supplies and related equipment except those used in connection with the treatment of diabetes;
- Equipment, models, or devices that have features over and above that which is Medically Indicated;
- Supplies including but not limited to shoes and/or Orthotics that are NOT custom made and can be purchased over-the-counter;
- Any Durable Medical Equipment that can be used for work, athletics, or job enhancements;
- Motor vehicles, wheelchair lifts, scooters (except if criteria is met) and stair lifts;
- Purchases or lease of, or modifications to, residences, places of work or motor vehicles;
- Enteral feeding Disposable Supplies including but not limited to bags, tubing, non-prescription or over-the-counter enteral feeds/supplements; nutritional supplements; or vitamins.

## **PHASE II/OUTPATIENT CARDIAC REHABILITATION**

Physicians Plus will cover benefits for an exercise program for Phase II Cardiac Rehabilitation if it is provided at a Participating outpatient facility for one of the six conditions listed below and/or covered. Benefits are payable for up to 36 supervised and monitored exercise sessions per covered Illness or Injury in a 18 consecutive week period, starting with the first session in the outpatient exercise program. Additional benefits may be payable for additional sessions as determined by Physicians Plus.

Phase II cardiac rehabilitation services at a participating outpatient facility: will be covered for a Member with a recent history of 1) myocardial infarction (heart attack); 2) coronary by-pass surgery; 3) onset of stable angina pectoris; 4) onset of decubital angina; 5) heart-valve surgery; or 6) percutaneous transluminal angioplasty.

Physicians Plus will not cover cardiac rehabilitation for any conditions or diagnoses not listed above; maintenance rehabilitation therapy; Long Term and/or Maintenance Care/Therapy.

## **PHYSICAL, SPEECH, OCCUPATIONAL AND REHABILITATIVE THERAPY**

All therapy must be: (1) Medically Indicated, (2) performed by a Participating Provider, (3) for the treatment of an Acute Illness or Injury as determined by Physicians Plus, (4) not otherwise covered by this or any other Policy and/or program, including but not limited to school based and/or federally mandated programs.

Physicians Plus will cover up to a combined total of 50 visits per Member per Contract Year for outpatient physical, speech, occupational and rehabilitative therapy (including LIMITED Biofeedback). A copayment may apply please refer to your schedule of benefits for details. All therapy must begin within 90 days of the Acute Illness or Injury. No Long Term Care/Therapy or Maintenance Care/Therapy will be covered. See definitions of Long Term Care/Therapy and Maintenance Care/Therapy.

#### LIMITATIONS ON COVERAGE:

- (1) Biofeedback for stress urinary & colorectal incontinence: will be limited to code 90911, defined as biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry. Biofeedback sessions will apply to the combined total 50-visit therapy limitation above.
- (2) Developmental delay services are limited to one evaluation visit and up to a maximum of 3 visits per therapy (physical, speech and occupational) per Member per Contract Year. Any treatment beyond the one evaluation visit and 3 therapy visits per therapy, per Member, per Contract Year is not covered under this Policy.
- (3) Speech and hearing screenings or examinations are limited to the routine screening tests performed by a Participating Provider for evaluating the need for any speech or hearing correction.

Physicians Plus will not cover:

1. Treatments, services, and supplies: that a third party (other than the Member's PCP) requires the Member to receive; covered under Workers' Compensation, school or educational programs, state and/or federally mandated school or educational programs; covered by another payor;
2. Exercise classes or assessments, educational, recreational or physical fitness programs and/or therapy;
3. Vocational rehabilitation programs including work hardening;
4. Coma rehabilitation and coma stimulation therapy;
5. Long Term brain Injury therapy;
6. Long Term and/or Maintenance Care/Therapy for stroke;
7. Cardiac rehabilitation except for the Phase II services described and listed in the previous section;
8. Orthoptic training/therapy;
9. Long Term and/or Maintenance Care/Therapy for multiple handicaps;
10. Pediatric therapy except for an Acute Illness or Injury;
11. Massage therapy except when provided during physical therapy for an Acute Illness or Injury;
12. Therapy for behavioral disorders not related to an Acute Illness or Injury ;
13. Home instructional therapy. These services are normally associated with, but not limited to, the following diagnoses:
  - Attention deficit/hyperactivity\*;
  - Sensory deficit/defensiveness\*;
  - Auditory deficit/defensiveness\*;
  - Mental retardation and related conditions\*;
  - Perceptual disorders except as listed above in the limited benefit for developmental delay\*.

\*This is not an all-inclusive list of diagnoses for which therapies are primarily performed in the Member's home for home instruction and monitoring. Long Term and/or Maintenance Care/Therapy are NOT covered in any setting (home, Physician's office, outpatient Hospital) under this Policy.

**PRESCRIPTION DRUGS, OUTPATIENT - NOTE:** NOT ALL policies sold by Physicians Plus include coverage for outpatient prescription drugs. Coverage is indicated on Your Physicians Plus Identification Card (RX) and/or You can check with Your group administrator. Non-group plans DO NOT include prescription drug coverage.

When coverage is purchased, Physicians Plus will cover drugs that: by law require a written prescription; are prescribed by a Participating Provider for treatment of a diagnosed Illness or Injury; and are purchased from a participating pharmacy. Drugs purchased in connection with Emergency Medical Care or Immediate/Urgent Medical Care services are not subject to the requirement that they be purchased from a participating pharmacy.

All prescription drug benefits are subject to the applicable benefit, Deductible, Copayment and/or Coinsurance as shown in the appropriate Drug and/or Medical Schedule of Benefits for Your Policy.

Physicians Plus maintains a Drug Formulary as a guide for Physician prescribers of ambulatory medications. The Physicians Plus Pharmacy and Therapeutics Committee, made up of Physicians and pharmacists, reviews and approves the agents listed based on efficacy, comparative studies, safety, drug interactions, side effects, pharmacokinetics and cost-effectiveness. Prescribers are notified quarterly about Formulary updates and changes. Physicians Plus reserves the right to change the Formulary at any time without notice. The Physicians Plus web site maintains a current version of the Drug Formulary at [www.pplusic.com](http://www.pplusic.com). Physicians Plus has a process through which a Physician may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device not routinely covered under the Policy.

Physicians Plus assigns drugs to the Biopharmaceutical category based upon the need to provide exceptional management such as: prior authorization; clinical oversight; cost; disease management and/or case management.

Pharmacological products for tobacco cessation, as selected by Physicians Plus, that are prescribed by a Participating Provider for the purpose of achieving tobacco cessation (i.e. Zyban, or similar medication, alone or in combination with a nicotine replacement product such as a nicotine inhaler, spray or patch) are limited to a maximum of one three-month course of pharmacotherapy per Member per Contract Year.

**LIMITATIONS:** Prescription drugs are dispensed and paid according to the drug's tier placement, as determined by the Physicians Plus Formulary. Your Plan may include a Deductible, Coinsurance, Copayments and/or maximums. Refer to Your Drug and/or Medical Schedule of Benefits for details about YOUR Plan.

Certain Formulary and Biopharmaceutical Drugs may require Prior Authorization before being obtained from a Participating pharmacy. You may contact the Participating Prescribing Physician or a Participating pharmacy for information on a particular drug, or contact the Member Service Department at (608) 282-8900 or (800) 545-5015 for a listing of drugs that require Prior Authorization. For drugs that are not on Our Formulary, your Physician may request Prior Authorization for an exception that would permit coverage in your particular situation. To request Prior Authorization the prescribing Physician must submit medical evidence to support the prescription request. Unless otherwise specified in Your prescription drug or medical Schedule of Benefits, prescription drugs covered under this section will be dispensed subject to the following quantity limitations:

1. Legend brand and generic drugs shall not exceed a 30-day supply or the smallest indivisible commercial package, whichever is greater, per Copayment or Coinsurance.
2. Single packaged items are limited to no more than two of any kind or a one month supply, whichever is less, per Copayment. A single packaged item includes, but is not limited to, inhalers, blood glucose testing strips, eye drops, and ear drops. Oral contraceptives are not considered single packaged items.
3. Female hormones, including but not limited to, oral contraceptives and cyclical hormone replacement, shall be dispensed per monthly cycle, and one Copayment will be charged per monthly cycle. Oral contraceptives may be obtained in a quantity of 3 cycles with appropriate Copayment or Coinsurance per cycle.
4. Quantity limitations based on FDA dosage recommendations may be in place for some medications and age and gender limitations may apply to some medications.
5. Quantity limitations may be in place for some additional medications. Check Your Schedule of Benefits for further information.
6. Branded generic drugs, which are sold as brand drugs by the manufacturer, have a brand Copayment or coinsurance amount. See Your drug Schedule of Benefits for an explanation of Deductible, Coinsurance, Copayments and maximums related to Your Plan.

## **Physicians Plus will not cover:**

1. Charges for prescription drugs that require Prior Authorization, unless the drug is approved by Physicians Plus prior to being obtained from a participating pharmacy.
2. Medications used for cosmetic purposes; sexual dysfunction; or weight loss or the treatment of obesity or morbid obesity, even if You have other health conditions that might be helped by the reduction of weight.
3. Over the counter drug items and tobacco cessation products except as approved by Physicians Plus.
4. All compounded estrogen, progesterone or testosterone products; oral progesterone products unless specifically included in the Physicians Plus Formulary; anabolic steroids except for replacement therapy; and drugs intended to modify stature except as approved by Physicians Plus.
5. Drugs whose actual Charge is less than the required Deductible, Coinsurance, or Copayment.
6. Dispensing charges for unit dose medications, costs related to the administration of a covered drug by injection or other means, and medications provided in connection with Intermediate Nursing Care, Custodial or Maintenance Care or Respite or Rest Care.
7. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by Physicians Plus.
8. Replacement of lost, stolen or forgotten prescription drugs are not covered.
9. Medications administered in the Physician's office.
10. Medications covered by Workers Compensation insurance, or furnished by the U.S. Veterans Administration or any other state or federal agency or Medicare.
11. Drugs and medicines not Medically Indicated or not appropriate for the treatment of an Illness or Injury as determined by Physicians Plus, except for specified drugs for the treatment of HIV infection as required by Section 632.895(9), Wis. Stats.
12. Drugs and medicines for, leading to, or after, sex-transformation surgery, including, but not limited to, sex hormones related to such surgery.
13. Drugs and medicines used for in vitro or in vivo fertilization of an ovum. Other infertility drugs may or may not be covered depending upon Your benefits.
14. Nutri-ceuticals, alternative drugs, natural remedies, homeopathic therapies and any other chemical, drug, medication, agent, or therapy which has not been reviewed and approved by the Federal Food and Drug Administration for use in humans, unless approved by Physicians Plus.
15. Any drug not listed on the Physicians Plus Drug Formulary.

Existing drugs, previously included on the Physicians Plus Formulary may be removed at any time when a therapeutically equivalent alternative drugs are available and covered under this Certificate. New drugs are excluded but may be added to coverage after the therapeutic advantages of the drug and its medically appropriate application are determined. Certain drug products may be excluded when comparable generic or therapeutic alternatives are available.

## **RADIATION THERAPY**

Physicians Plus will cover therapy and therapeutic methods of radiation therapy, such as x-rays, radium and radioactive isotopes, when the services are Medically Indicated and provided by a Participating Provider.

Physicians Plus will not cover services not listed above.

## **SURGICAL SERVICES**

Subject to the applicable Policy exclusions and/or benefit Deductible, Copayment, Coinsurance and maximums listed in Your Schedule of Benefits, Physicians Plus will cover Medically Indicated surgical procedures for the treatment of an Illness and/or Injury.

Services covered include: pre-operative and post-operative care, and elective sterilization (unless excluded in Your Schedule of Benefits).

Most Surgical Services with a Participating Provider do not require Prior Authorization. However, if the surgical procedure/service could be considered cosmetic in nature (e.g. mammoplasty, rhinoplasty), the Member is encouraged to ask the Provider to send us information and to obtain Prior Authorization.

The following plastic, reconstructive and cosmetic Surgical Services are covered when Prior Authorized by Physicians Plus.

- (A) Correction of congenital anomalies to restore physiologic function (e.g. cleft palate).
- (B) Restoration of appearance following accidental trauma or covered surgery if the causative incident occurred while a Member of Physicians Plus and the restoration begins within one year of the incident.
- (C) Treatment for microtia.
- (D) Emergency treatment of traumatic injuries (e.g. facial lacerations, amputation).
- (E) When plastic or reconstructive services are incidental but required to remove pathologic tissue (e.g. skin cancer).
- (F) When Federal or State mandates entitle Members to plastic surgery services, such as; the Woman's Health and Cancer Rights Act of 1998 which mandates coverage for the following, if You are receiving benefits in connection with a mastectomy and elect breast reconstruction surgery in connection with that mastectomy: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; (3) Prostheses and physical complications of all stages of a mastectomy, including lymphedemas.
- (G) Penile Implants will be covered when Prior Authorized by Physicians Plus. The Member must meet the Physicians Plus medical Policy criteria for medical appropriateness of the surgery, as determined by Physicians Plus.
- (H) One Cochlear Implant and related services when the Member does not have a functioning cochlear implant to correct total deafness. Coverage is limited to one implant per Member up to the limits of the Policy. The Cochlear implantable device is subject to 20% coinsurance and will not apply to any maximum out of pocket. All services and related services must be Prior Authorized and Medically Indicated, as determined by Physicians Plus.

Physicians Plus will not cover: services not specifically listed as a covered service; a sex transformation; reversal of voluntary sterilization procedures and related procedures; cosmetic or plastic surgery unless representing a medical/surgical necessity and approved by Physicians Plus (psychological reasons do not represent a medical/surgical necessity); any surgical procedure or service for the treatment of obesity or morbid obesity, including but not limited to gastric and intestinal bypasses, gastric balloons, stomach stapling, liposuction, and wiring of the jaw, even if You have other health conditions that might be helped by the reduction of weight; keratorefractive eye surgery, including but not limited to radial keratotomy; exclusions listed elsewhere in this Policy.

## **TERMINATION OF PREGNANCY**

Physicians Plus will cover the termination of pregnancy when performed by a Participating Provider **ONLY** in accordance with the following conditions: the termination is performed during the first 20 weeks of gestational age; and the termination of pregnancy is permitted by and performed in accordance with the law.

Physicians Plus will not cover the termination of a pregnancy when it does not meet the criteria outlined above.

## **TRANSPLANTS - TISSUE/ORGAN**

Physicians Plus will cover the transplants listed below. Physicians Plus must Prior Authorize all transplants and related treatment, services and supplies, including transplant work-ups, in order for any services to be covered. Each potential transplant must be Medically Indicated for the medical condition for which the transplant is proposed, as determined by Physicians Plus.

Transplant surgery must be performed at a facility approved in writing by Physicians Plus in advance of the surgery. Transplants (except for kidney transplants) are limited to the initial transplant of the original organ per lifetime and are subject to a the Policy Lifetime Maximum benefit of \$500,000 for all transplants (except kidney transplants, the coverage for which is discussed in the BENEFITS AND SERVICES-KIDNEY DISEASE/TRANSPLANT section of this Certificate).

Coverage includes drugs and medications while confined in a Hospital or medical facility, including post transplant take home drugs (one time only). Transplant coverage does not include outpatient prescription drugs related to the transplant.

Transplant services, tests, procurement and procedures pre- or post-transplant will be applied to the transplant lifetime Policy maximum. The transplant maximum is included in the Maximum Lifetime benefits.

When the recipient and the donor are covered Members under the Physicians Plus Policy, the donor's expenses shall be deemed to be expenses of the recipient. Donor expenses shall be limited to only those treatment, services and supplies that are not provided or available to the donor from any other source. When only the donor is covered under the Policy, no expense will be eligible.

Physicians Plus will cover the following transplants:

- (A) **Autologous (self-to-self) and allogeneic (donor-to-self) bone-marrow or peripheral stem cell transplantation** for treatment of: congenital immunodeficiencies (such as severe combined immunodeficiency), Wiskott-Aldrich syndrome; aplastic anemia; Acute leukemia; chronic myelogenous leukemia; Hodgkins and non-Hodgkins lymphoma; multiple myeloma; recurrent or refractory neuroblastoma; and germ cell tumors of the testis, ovary, mediastinum, and retroperitoneum.
- (B) **Corneal transplantation (keratoplasty)** for treatment of: corneal ulcer, keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or a Member who cannot wear a contact lens or for repair of severe lacerations. One transplant per eye; re-transplantable one time per eye.
- (C) **Heart, heart/lung transplantation** for treatment of: congestive cardiomyopathy, end-stage ischemic heart disease; hypertrophic cardiomyopathy; terminal valvular disease; congenital heart disease; cardiac tumor; myocarditis; coronary embolization; or post-traumatic aneurysm.
- (D) **Kidney (Renal) transplantation** for the treatment of end-stage renal disease or diabetes complications. (See benefits section under **KIDNEY DISEASE TRANSPLANT**).
- (E) **Liver transplantation** for treatment of biliary atresia in children 18 years and younger or for treatment of: extrahepatic biliary atresia; inborn error of metabolism (alpha-1-antitrypsin deficiency, Wilson's disease, glycogen-storage disease, tyrosinemia or hemochromatosis); primary biliary cirrhosis; hepatic vein thrombosis; sclerosing cholangitis; post-necrotic cirrhosis (HBeAg negative); chronic active hepatitis (HBeAg negative); primary non-metastatic liver cancer; or alcoholic cirrhosis (if the patient has abstained from alcohol for six (6) or more consecutive months immediately preceding the transplant).
- (F) **Lung transplantation** for the treatment of end stage pulmonary disease not amendable or responsive to alternative therapeutic approaches in patients who can tolerate the procedure and do not have coexisting conditions that would impair the success of the transplant as determined by Physicians Plus.
- (G) **Musculoskeletal transplantation** intended to improve both the function and appearance of any body area that has been altered by disease, trauma, congenital anomalies or previous covered therapeutic processes.
- (H) **Pancreas transplantation**, only at the time of a kidney transplant for treatment of end-stage renal disease or diabetes complications.

Coverage for organ-procurement costs is limited to expenses directly related to the procurement of an organ from a cadaver or a donor having a blood relationship to the recipient. Organ-procurement costs include organ transplantation, compatibility testing, hospitalization, and surgery (when a live donor is involved). Organ procurement costs are subject to the transplant lifetime benefit maximum of the Policy.

## Physicians Plus will not cover

- Transplants and related expenses, except those outlined as covered procedures in this Certificate or Your Schedule of Benefits;
- The purchase of an organ;
- Cell transplantation and/or therapy;
- Retransplantation services (whether or not the initial transplant was covered under this Policy), except corneal and kidney retransplantation (see corneal transplantation and kidney transplantations above);
- Services and supplies in connection with covered transplants unless Prior Authorized by Physicians Plus prior to services being rendered;
- Any Experimental or Investigational transplant, or any other transplant-like technology not listed; and any resulting complication from these, and any services and supplies related to such Experimental or Investigational transplantation or complications including, but not limited to: high dose chemotherapy; radiation therapy of immunosuppressive drugs;
- Any transplant involving non-human, artificial or mechanical device and/or organ;
- Any transplant procedure, organ or tissue transplant and/or services not listed above.

## VISION SERVICES

Physicians Plus will cover one routine eye exam and refraction in connection with the eye exam per Member per Contract Year; the initial lens per surgical eye following cataract surgery (contact lens or framed lens).

Physicians Plus will not cover services obtained from a Non-Participating Provider or procedures to correct myopia, hyperopia and astigmatism, including but not limited to: laser photokeratotomy; laser keratectomy; refractive keratoplasty; radial keratectomy; keratotomy; excimer laser photorefractive keratectomy and/or medications associated with these procedures and/or complications.

## 5. GENERAL POLICY EXCLUSIONS AND LIMITATIONS

---

### THE FOLLOWING GENERAL EXCLUSIONS AND LIMITATIONS APPLY TO ALL SERVICES

General Policy exclusions and limitations not listed elsewhere in this Policy are listed in this section. See specific benefits and services for additional exclusions and limitations.

### Physicians Plus will not cover:

- a. Any services performed by a Non-Participating: Physician, Hospital, facility or other Provider.
- b. Any services for which Prior Authorization was required but not obtained. It is the Member's responsibility to obtain the proper Prior Authorization.
- c. Any treatment, services and supplies not specifically identified as being covered under this Policy; and any treatment, services and supplies required in connection with, in follow up to, or as a result of a treatment, service or supply not covered under this Policy.
- d. Paternity testing.
- e. Cytotoxic testing in conjunction with allergy testing.
- f. Hair analysis, unless lead or arsenic poisoning is suspected.
- g. Coma stimulation programs.
- h. Orthoptics (eye exercise training).
- i. Long Term and/or Maintenance Care/Therapy.
- j. Massage therapy (except when provided during physical therapy for an Acute Illness or Injury).
- k. A second opinion by a Non-Participating Provider.
- l. Eye glasses, contact lenses, sun glasses, frames and/or the fitting of frames (except as specifically listed in this Certificate under the BENEFIT AND SERVICES section).
- m. Charges for telephone consultations by and between Providers.
- n. Charges for any missed appointments.
- o. Expenses for medical records and/or reports, including but not limited to, the preparation and presentation of these reports.
- p. Chelation therapy for arteriosclerosis.

- q. Complications related to cosmetic body piercing, tattooing, implants or other services or procedure that are not Medically Indicated or not performed by a licensed medical professional.
- r. Services and supplies that are not Medically Indicated and/or are not appropriate to the treatment of an Illness or Injury, as determined by Physicians Plus.
- s. Services and supplies provided while a Member's coverage is/was not in effect under this Policy (except as specified in the Extension of Benefits section of this Certificate).
- t. Treatment, services and supplies that a third party (other than the Member's PCP) requires the Member to receive; treatment, services and supplies for which another party is liable as determined by Physicians Plus, including, but not limited to: Workers' Compensation, school-based programs, federally mandated programs, Medicare, work-related services including employment physicals, tests, and exams and exams requested or directed by a court of law. If benefits are paid or provided by Physicians Plus whenever this exclusion applies, Physicians Plus reserves all rights to recover the reasonable value of such benefits, including as provided in the section of this Certificate entitled OTHER POLICY PROVISIONS - DIRECT PAYMENTS AND RECOVERY.
- u. Services, supplies or other care for Injury or Illness for which there is non-group insurance (except individual health insurance policies) providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent to this Certificate. If benefits subject to this provision are paid or provided by Physicians Plus, Physicians Plus reserves all rights to recover the reasonable value of such benefits as provided in the section of this Certificate entitled OTHER POLICY PROVISIONS-SUBROGATION and REIMBURSEMENT.
- v. Treatment and services for an Illness or Injury caused by atomic or thermonuclear explosion or resulting radiation, or any type of military action, friendly or hostile.
- w. Treatment, services and supplies incurred in connection with any Injury or Illness arising out of, or in the course of, any employment for which an employer either is required to carry or does carry Workers Compensation insurance. If Worker Compensation or any similar law applies to the Member, this exclusion applies regardless of whether benefits under Workers Compensation or any similar law have been claimed, paid, waived or compromised. If benefits are paid or provided by Physicians Plus in a contested Workers' Compensation proceeding, or whenever Workers Compensation benefits may be payable, Physicians Plus reserves all rights to recover the reasonable value of such benefits as provided in the section of this Certificate entitled OTHER POLICY PROVISIONS- WORKERS COMPENSATION.
- x. Treatment and services furnished by the U.S. Veterans Administration except when coverage is required under applicable federal law.
- y. Treatment and services provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or facility or while in the custody of law enforcement officials, except as required by state or federal law. Persons who are injured or become ill while outside of the institution or facility and while on work release are not considered to be held, detained or imprisoned if they are otherwise eligible Members.
- z. Treatment and services in connection with any Illness or Injury caused by a Member's: engagement in an illegal occupation; commission of, or an attempt to commit, a felony; or intentional use of illegal drugs.
- aa. Reconstructive Surgery/Cosmetic Treatment, except as indicated in this Policy. NOTE: Psychological reasons do not represent a medical or surgical necessity.
- bb. Treatment to correct or reverse complications and/or dissatisfaction resulting from surgery, Cosmetic Treatment, or reconstruction when no functional impairment exists, as determined by Physicians Plus.
- cc. Injection of filling material such as collagen, salabrasion, rhytidectomy, dermabrasion, chemical peel.
- dd. Suction-assisted lipectomy.
- ee. Electrolysis.
- ff. Mastopexy\*.
- gg. Augmentation mammoplasty\*;
- hh. Correction of inverted nipples\*;
- ii. Reduction mammoplasty (unless You meet the Physicians Plus medical policy criteria)\*;
- jj. Sclerosing of spider veins.
- kk. Panniculectomy.
- ll. Mastectomy for male gynecomastia.

- mm. Experimental/Investigational treatments, drugs, devices and/or procedures a Physicians Plus medical director deems Experimental based on Specific Evidence (except HIV-related treatments and drugs authorized by Physicians Plus).
- nn. Any treatment, service or supply that is received in a Hospital emergency room (whether received from a Participating Provider or non-Participating Provider) and that does not meet the definition of Emergency Medical Care.
- oo. Any treatment, service or supply related to the purpose of medical research and/or clinical research trials (except for routine patient care that must be covered under section 632.87(6)(b) of the Wisconsin statutes when administered in a cancer clinical trial).
- pp. Acupuncture, hypnotism, goal-oriented behavioral modification, and biofeedback.
- qq. Treatment, services and supplies for holistic or homeopathic medicine, or programs that are not accepted medical practice as determined by Physicians Plus.
- rr. Treatment, services and supplies for, or leading to, sex-transformation surgery and sex hormones related to such treatment.
- ss. Take home drugs and outpatient prescription drugs not specifically covered under this Policy.
- tt. Any service, supply, equipment, medication or other benefit for the treatment of obesity or morbid obesity, including but not limited to gastric and intestinal bypasses, gastric balloons, stomach stapling, wiring of the jaw, liposuction, and weight loss, physical fitness and exercise programs and equipment, even if You have other health conditions that might be helped by the reduction of weight;
- uu. Nutritional supplements and/or vitamins;
- vv. Lodging expenses.
- ww. Transportation expenses (except for covered ambulance transport as outlined in the benefits sections of this Policy).
- xx. Treatment, services and supplies provided by a Member or a Member's Immediate Family or anyone else living with the Member; and/or treatment, services or supplies provided to or received by a Member as a collateral in connection with the treatment of any person who is not a Member under this Certificate.
- yy. Autopsy services.
- zz. Treatment, services and supplies for which the Member has no obligation to pay.
- aaa. Amounts in excess of the Usual and Customary charge for the covered service, treatment or supply.

\* Exclusion does not apply where the Women's Health and Cancer Rights Act of 1988 mandates coverage. See BENEFITS AND SERVICES-SURGICAL SECTION of this Certificate.

## 6. EFFECTIVE DATES AND ELIGIBILITY

---

*Please notify Your employer (if applicable) and Physicians Plus immediately following a life event (e.g. marriage, birth, adoption, divorce or annulment, loss of coverage and other such changes in coverage).*

### ELIGIBILITY

A person is an **Eligible Employee** if he/she:

- (A) Appears on the Policyholder's regular payroll records (excluding temporary and/or leased employees);
- (B) is scheduled to perform the duties of his/her job with the Policyholder for at least the minimum number of hours per week as required on the policyholders current application for coverage (the required minimum shall not exceed 30 hours per week);
- (C) is Actively at Work (except where immediate coverage is required under Ins. 6.5I of the Wisconsin Administrative Code or HIPAA); and
- (D) has completed the waiting period, if any, for coverage to be effective as specified by the Policyholder's application for coverage.

**Eligible Dependents** Eligible Dependents include any of the following who meet the other requirements of the Policy (such as age limits): a covered employee's spouse, child, stepchild, adopted child, Legal Ward, and grandchild (so long as the grandchild's parent is a covered dependent and under age 18), and a child placed for adoption with the Eligible Employee.

For the covered employee's child, stepchild, adopted child, Legal Ward, or child placed for adoption with the employee to be eligible, the child generally must not exceed the Maximum Dependent Age of age of 26, must not be married and must not be eligible for coverage under a group health benefit plan that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his/her coverage as a dependent under this Policy. Please see the "DISENROLLMENT AND WHEN COVERAGE ENDS" section of this Certificate for the exceptions to these age requirements for certain children having mental or physical handicap and a student on medical leave.

## **EFFECTIVE DATES OF COVERAGE**

To be enrolled, coverage must be applied for and approved by Physicians Plus and the required premium must be received by Physicians Plus. Except in cases of continuation coverage, Eligible Dependents can be covered under this Policy only if the Eligible Employee is covered. Except for Late Enrollment (discussed below) and the special enrollment period (discussed below), coverage will become effective on the following dates:

**For an Eligible Employee**, coverage generally will be effective on the latest of:

- (A) the effective date of the Group Master Policy between Physicians Plus and the Policyholder; and
- (B) when the employee has satisfied all the requirements to be an Eligible Employee, including completion of any waiting period specified by the Policyholder in its application for coverage.

Coverage will be delayed if the Eligible Employee is not Actively at Work on the date coverage otherwise would begin (unless that date falls on a non-working day and the employee was Actively at Work on the immediately preceding working day, or except as required by Ins. 6.51 or HIPAA). If coverage is delayed for this reason, coverage for the Eligible Employee and his enrolled Eligible Dependents will begin on the next day the eligible employee is Actively at Work.

Coverage also will not be effective if the Eligible Employee fails to apply for coverage: (i) during the Policyholder's annual enrollment period, or (ii) for an employee who was not eligible during the annual enrollment period, within 31 days of beginning work for the minimum number of hours per week that the Policyholder requires for an employee to be eligible for health insurance coverage. In those situations, the employee will be considered to be a Late Enrollee.

**For an Eligible Dependent**, coverage will be effective on:

- (A) the date the Eligible Employee is enrolled for coverage in the case of dependents who then qualify as eligible dependents;
- (B) the date of the Eligible Employee's marriage in the case of the spouse and any stepchild acquired on that date;
- (C) the date of birth of the Eligible Employee's natural-born child;
- (D) the date a child is placed for adoption (as defined in Section 632.896(1) of the Wisconsin Statutes) in the eligible employee's home or the date that a court issues a final order granting adoption of the child to the eligible employee, whichever occurs first;
- (E) the date of the court order appointing the covered employee or his/her covered spouse as guardian in the case of a Legal Ward;
- (F) the date of birth for a child born to an Eligible Employee's covered child who is under the age of 18.
- (G) the date the dependent child returns from serving in the military and becomes a Full-Time Student IF the dependent child was a full time student under age 27 when he/she was called to federal active duty with National Guard or in a reserve component of the U.S. armed services.

When coverage is first requested under (G) and annually thereafter, We may require documentation that a child meets those criteria for coverage.

Except for newborns, adopted children (which is discussed below) and children placed for adoption with the Eligible Employee (which is discussed below), an application must be received by Physicians Plus within 31 days of eligibility or the individual will be subject to a waiting period unless he/she is considered for a special enrollment. See "SPECIAL ENROLLMENT PERIODS" AND "LATE ENROLLMENT" below.

**SPECIAL WISCONSIN RULE FOR DEPENDENT'S MEDICALLY NECESSARY LEAVE OF ABSENCE FROM SCHOOL** – this section only applies when the Covered Dependent had coverage beyond the Maximum Dependent Age as a Full-Time Student after being called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces.

A dependent who was covered as a Full-Time Student shall continue to be eligible for coverage if, due to a medically necessary leave of absence, he/she ceases to be a Full-Time Student.

A dependent is only eligible for this special continuation of coverage if he/she notifies Us within thirty (30) days of ceasing to be a Full-Time Student and submits documentation and certification to us of the medical necessity of the leave of absence from his/her Attending Physician. The date the dependent ceases to be a Full-Time Student due to the medically necessary leave of absence shall be the date on which this special continuation coverage begins.

This special continuation coverage ends when any of the following happen:

1. The dependent advises Us that he or she does not intend to return to school full time.
2. The dependent becomes employed full time.
3. The dependent obtains other health care coverage.
4. The dependent marries and is eligible for coverage under his or her spouse's health care coverage.
5. Coverage of the Subscriber through whom the person has dependent coverage under the policy is discontinued or not renewed.
6. One year has elapsed since the dependent's special continuation coverage under this provision began and the dependent has not returned to school full time.

### **SPECIAL RULES FOR NEWBORNS, ADOPTED CHILDREN AND CHILDREN PLACED FOR ADOPTION**

**Newborns.** Coverage for a newborn of an Eligible Employee who is covered under the Policy is effective from the moment of birth.

In the event of a newborn, please submit Your application for coverage of the newborn to Physicians Plus as soon as possible. If more than one insurance Policy will cover the newborn, please notify all applicable plans as soon as possible. If Physicians Plus is obligated to cover a newborn, all requirements of the Policy must be satisfied for services to be covered, including authorizations for inpatient services for the birth of the child.

If coverage of the newborn results in an increased premium, You must submit Your application and the required premiums to Physicians Plus within 60 days. If You do not comply with that 60-day requirement, coverage of the newborn will terminate after that 60 days unless, within one year of the birth, You apply and pay Physicians Plus all back premiums plus interest at a rate of 5.5%. If coverage terminates for the newborn, he/she will be considered a late entrant and must serve a 12-month waiting period.

**Adopted Children and Children placed for adoption.** Coverage for an adopted child is effective on the date that a court makes a final order granting adoption of the child to the Eligible Employee. Coverage for a child who is placed in the Eligible Employee's home for adoption is effective on the date the child is "placed for adoption" as defined in Section 632.896(1) of the Wisconsin Statutes. You must notify Us that the child is adopted or placed for adoption and pay Us any premium required to provide coverage for the child within 60 days or the child will be considered a late entrant and must serve a 12-month waiting period.

## **SPECIAL RULES RELATED TO MEDICAID AND CHIP**

An Eligible Employee or an Eligible Dependent may enroll outside the normal enrollment period if: (1) the Eligible Employees or Eligible Dependents coverage under Medicaid or CHIP is terminated as a result of loss of eligibility for that coverage, or (2) the Eligible Employee or Eligible Dependent becomes eligible for a Medicaid or CHIP premium assistance subsidy. To qualify for this special rule, the Eligible Employee or the Eligible Dependent must request coverage under this Policy within 60 days of the termination of his/her Medicaid or CHIP coverage or within 60 days after he/she is determined to be eligible for the Medicaid or CHIP subsidy.

## **SPECIAL ENROLLMENT PERIODS**

If an Eligible Employee or an Eligible Dependent does not apply for coverage when initially eligible due to having other Creditable Coverage, he/she may be eligible for a special enrollment period if: (1) he/she was covered under health insurance coverage at the time of his/her initial eligibility; (2) he/she stated in writing at the time of initial eligibility that other health insurance coverage was the reason for declining enrollment; and (3) he/she applies for coverage no later than 31 days after the date on which the other coverage is exhausted or terminated.

## **LATE ENROLLMENT**

If an Eligible Employee or his/her Eligible Dependent does not apply for coverage within 31 days of initially becoming eligible for coverage and does not qualify for any of the above special rules for enrollment, the Eligible Employee and/or Eligible Dependent(s) will serve a 12-month waiting period, and coverage will be effective on the first day of the month following that waiting period. The 12-month waiting period will start on the first of the month following Our receipt of the application.

## **7. OTHER POLICY PROVISIONS**

---

### **YOUR PHYSICIAN, HOSPITAL OR OTHER HEALTH CARE PROVIDER**

Physicians Plus will not interfere with the professional relationship a Member has with a Physician, Hospital or other health care Provider. However, in order to be covered, treatment, services and supplies must be provided by:

- a. A Member's Primary Care Physician (PCP); or
- b. A participating facility, Provider or Physician;
- c. A Provider/Physician other than an Participating Provider when a Member is referred by the PCP and Physicians Plus approves and/or Prior Authorized the services;
- d. A Provider/Physician other than a Participating Provider when a Member requires Emergency Medical Care;
- e. A Provider/Physician other than a Participating Provider if a Member is a dependent student while away at school;
- f. A Hospital when referred by a Physician as described in (a), (b), (c), or (d) above and Prior Authorized by Physicians Plus; or
- h. A Participating Hospital.

Physicians Plus is not responsible for any Injury, damage, or expense (including attorneys fees) a Member suffers as a result of any improper advice, action or omission on the part of any Physician, Hospital or other health care Provider. Physicians Plus is obligated to provide only the benefits specifically stated in the Policy.

## CONTINUITY OF CARE

Pursuant to Wisconsin State Statute 609.24, Physicians Plus will continue to provide coverage for services You receive from a Participating Provider who terminates participation with Physicians Plus, under the following circumstances:

- The Provider continues to practice within the Service Area;
- The Provider's participation with Physicians Plus did not terminate because of the Provider's misconduct;
- Physicians Plus represented that the Provider was, or would be, a Participating Provider in marketing materials provided or available to You at the time of Your initial enrollment, most recent coverage renewal, or most recent open-enrollment period, whichever is later;
- If the Provider is the Member's PCP at the time the Provider's participation terminates, Physicians Plus will continue to cover primary care services provided by that Physician until the end of the Plan year for which Physicians Plus represented that the Provider was, or would be, a Participating Provider;
- If You are undergoing a course of treatment with a Provider other than Your PCP at the time the Provider's participation terminates, Physicians Plus will continue to cover services from that Provider for the shortest of the following periods of time:
  1. For the remainder of the course of treatment;
  2. For 90 days after the Provider's participation terminates; or
  3. Until the end of the current Plan year for which Physicians Plus represented that the Provider was, or would be, a Participating Provider whichever is shorter.
- If the Member is receiving Maternity care from a Provider and the Member is in the second or third trimester of pregnancy when the Provider's participation terminates, Physicians Plus will continue to cover services from that Provider until the completion of postpartum care for the mother and infant.

**Services or supplies provided or ordered by a Physician other than a Participating Physician, except as stated above, are NOT covered.**

## CASE MANAGEMENT ALTERNATE TREATMENT/CONFINEMENT

The following definition applies to this provision only: Authorized Representative means a person a Member designates in writing to act on behalf of or for the Member.

### Alternate Treatment

When medically appropriate, as determined by Physicians Plus, Physicians Plus may suggest that a Member consider an alternate treatment of a covered Illness or Injury which differs from the current treatment of that Illness or Injury if it appears that:

The alternate treatment offers a medically therapeutic value at least equal to the current treatment, and the current treatment may be changed without jeopardizing the Member's health.

Physicians Plus will contact the Member's Attending Physician to:

- (A) Suggest consideration of the alternate treatment;
- (B) Advise of the possible benefits payable by Physicians Plus for such treatment; and
- (C) Answer any questions the Attending Physician may have.

### Alternate Confinement

When medically appropriate, as determined by Physicians Plus, Physicians Plus may suggest that a Member confined in a Hospital for a covered Illness or Injury consider transferring to another institution if it appears that:

- (A) The other institution can provide the necessary medical care; and
- (B) The physical transfer would not jeopardize the Member's health or the medical effectiveness of the current treatment.

Physicians Plus will contact the Member's Attending Physician to:

- (A) Suggest consideration of the alternate Confinement;
- (B) Advise of the possible benefits payable by Physicians Plus for such Confinement; and
- (C) Answer any questions the Attending Physician may have.

Physicians Plus will send a letter to the Member or Authorized Representative and the Attending Physician. That letter will provide a description of the alternate treatment or alternate Confinement and the possible benefits payable by Physicians Plus services.

If the Member or Authorized Representative and the Attending Physician agree to the alternate treatment and/or alternate Confinement at a different institution/location, the letter must be signed by the Member or Authorized Representative and the Member's Attending Physician. The signed letter must be promptly returned to Physicians Plus. The alternate treatment or alternate Confinement must begin as soon as reasonably possible. If the Member or Authorized Representative and/or Attending Physician do not agree with the alternate treatment or alternate Confinement, benefits for the current treatment or Confinement remain payable as provided under the Policy, including the limitation that services must be provided by a Participating Provider. Acceptance of the alternate treatment or alternate Confinement does not necessarily prevent a change in treatment at a subsequent time.

In the event that the alternate treatment or Confinement includes medical care or services for which benefits are not otherwise payable under the Policy, Physicians Plus will consider the payment of benefits under the Policy for such care or services as long as treatment or Confinement is medically appropriate, as determined by Physicians Plus, to treat the Member's covered Illness or Injury. Physicians Plus will determine benefits at the time of claim.

## **ASSIGNMENT OF BENEFITS**

This coverage is just for You and/or Your Eligible Dependents. Benefits may be assigned to a Provider to the extent allowed by Wisconsin insurance law and by other provisions in this Certificate.

## **SUBROGATION and REIMBURSEMENT**

When a Member receives a benefit under this Policy, Physicians Plus is subrogated to the Member's right to recover damages for Illness or Injury a third party caused or for which a third party is liable, to the extent of the reasonable value of the benefits provided to the Member. In providing benefits to a Member, Physicians Plus may obtain discounts from its healthcare Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the reasonable value of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under this Policy for an Illness or Injury, Physicians Plus is subrogated to the Member's right to recover the reasonable value of the benefit it provides on account of such Illness or Injury, which reasonable value shall be deemed to be the amount that Physicians Plus paid.

Physicians Plus's subrogation rights also include the right to recover against any insurance company that is in any way responsible for providing payment as a result of the Illness or Injury and pursuant to uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, travel insurance, automobile medical payments coverage, premises medical expense coverage and any other applicable insurance. Physicians Plus may pursue its right of subrogation against any party liable for the Member's Illness or Injury or any party that has contracted to pay on account of the Member's Illness or Injury. In the event a Member has received payment on account of his or her Illness or Injury that is work related and for which the Member might be eligible for Workers' Compensation, the Member agrees to reimburse Physicians Plus for the reasonable value of such benefits.

Any Member receiving a benefit shall:

- a. Respond to requests for information in a timely manner;
- b. Notify Physicians Plus with written notice of any claim or lawsuit that you initiate against a third party;
- c. Sign and deliver all papers Physicians Plus reasonably requests to protect or enforce its rights of subrogation or reimbursement;
- d. Do whatever else is necessary to protect or allow Physicians Plus to enforce its rights, including joining promptly upon request Physicians Plus as a party to any legal action commenced by the Member; and
- e. Not do anything before or after payment by Physicians Plus that would prejudice or reduce its rights.

Physicians Plus's rights of subrogation and reimbursement shall not apply unless the third party's payment has made or will make the Member "whole". A Member has been made whole when he or she is compensated for his or her damages, after discounting for any negligence attributable to the Member. If the Member's total recovery is reduced on account of the Member's negligence, Physicians Plus' right to recover shall be reduced to the extent of the Member's negligence. If a dispute arises over the issue of whether or not a Member has been made whole or the extent to which a Member may have been negligent, Physicians Plus reserves the right to a judicial determination of those issues.

Physicians Plus will not pay fees or costs associated with any claim or lawsuit unless it has previously agreed in writing to do so. Physicians Plus reserves the right to pursue independently and recover benefits provided by it.

## **WORKER'S COMPENSATION**

This Certificate is not issued in lieu of nor does it affect any requirements for coverage by Workers' Compensation. Treatment, services and supplies incurred in connection with any Injury or Illness arising out of or in the course of any employment for which an employer either is required to carry or does carry Workers' Compensation insurance are excluded from coverage by Physicians Plus. However, if benefits are paid by Physicians Plus and it is determined that a Member is eligible to receive Workers Compensation for the same incident, Physicians Plus shall have the right to recover the reasonable value (as set forth in the preceding Section) of any benefits so provided. As a condition of a Member receiving benefits on a contested work or occupational claim, the Member shall reimburse Physicians Plus at the time of receiving any recovery pursuant to any Workers' Compensation proceeding or any settlement and compromise or similar agreement and upon request shall sign a reimbursement agreement that so states. Physicians Plus reserves and shall have the right to recover against the Member even though:

- a. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
- b. No final determination is made that the Injury or Illness was sustained in the course of, or resulted from employment; or
- c. The amount of Workers' Compensation due for medical or health care is not agreed upon or defined by the Member or the Workers' Compensation carrier; or
- d. The medical or health care benefits are specifically excluded from or reduced in the Workers' Compensation settlement or compromise.

The Member shall not enter into a compromise or hold harmless agreement relating to any work related claims paid by Physicians Plus, whether or not such claims are disputed by the Workers' Compensation insurer, without the prior written agreement of Physicians Plus.

## **LIMITATIONS ON SUITS**

No action can be brought against Physicians Plus to compel payment of benefits under the Policy until the earlier of:

- a. 60 days after Physicians Plus has received or waived proof of claim; or
- b. The date Physicians Plus denies full payment. Action can be brought earlier if waiting will result in prejudice against a Member. However, the mere fact that the Member has to wait until the earliest of the above is not considered prejudicial. No action can be brought more than three years after the time We require written proof of claim. (See Proof Of Claim below.)

## **SEVERABILITY**

Any provision of the Policy that may be prohibited by Wisconsin law shall be void and be without force or effect. This will not invalidate the enforceability of any other term, condition or provision of the Policy.

## **PROOF OF CLAIM (POST SERVICE)**

A Member must submit written proof of claim to Us within 120 days of occurrence. We must receive:

- a. The completed claim forms if required by Physicians Plus;
- b. The actual itemized bills for treatment or service; and
- c. Any other information that We need to determine Our liability to pay benefits under the Policy.

Your failure to submit your proof of claim within 120 days of occurrence will invalidate the claim unless you show: (i) that it was not reasonably possible to provide proof of claim within the 120 days and that You provided proof of Your claim as soon as was reasonably possible; or (ii) that We were not prejudiced by Your failure to timely submit Your proof of claim. In all circumstances Physicians Plus will determine benefits at the time of claim. Claims will be processed and apply to any limits in the order they are received.

## **CONFORMITY WITH LAWS**

On the effective date of the Policy, any provision conflicting with federal or state laws applying to the Policy should be deemed to automatically conform to the minimum requirements of such laws.

## **ENTIRE CONTRACT/CHANGES**

The Policy (including the Group Master Policy, this medical Certificate, Schedule of Benefits, all amendments, addenda and riders, if any, the Policyholder's group application, the Policyholder's supplemental applications, if any, and Your application and supplemental applications, if any) make up the entire contract. Only an executive officer of Physicians Plus Insurance Corporation is authorized to add to or change any part of the contract. An amendment or provision attached to the Policy will show any such change or addition. No agent or other person has the power to change the contract or waive any term, condition or provision of the contract.

## **RESCISSION AND AVOIDANCE OF COVERAGE (FRAUD AND COVERAGE ABUSE)**

Physicians Plus is relying on the statement, representations and warranties made by the Policyholder in the negotiation of the insurance contract and by each Member in the application for coverage or other written document. Physicians Plus may rescind the Policy retroactive to its effective date if the Policyholder makes a fraudulent misrepresentation in its written application for the Policy. Physicians Plus also may rescind Your coverage and that of Your dependents under this Certificate or deny claims if You make fraudulent misrepresentation in Your application or other written document signed by You.

## **LIMIT ON CERTAIN DEFENSES**

After two (2) years have passed since a Member's effective date of coverage under the Policy, no misrepresentations made by You will be used to void coverage or to deny benefits for any claim beginning after the two-year period expires. This does not apply to fraudulent misrepresentations made in Your application or any supplemental applications.

## **DIRECT PAYMENTS AND RECOVERY**

- (A) **Direct Payment of Benefits:** unless otherwise specifically stated in the Policy, Physicians Plus has the option of paying benefits either directly to the Physician, Hospital or other health care Provider or to You. Payments for covered expenses for which We are liable may be paid under another group or franchise Plan or Policy arranged through Your employer, trustee, union or association. If so, We can discharge Our liability by paying the organization that has made these payments. In either case, such payments shall fully discharge Us from all further liability to the extent of benefits paid.

(B) **Recovery of Excess Payments:** if Physicians Plus pays more benefits than what We are liable to pay under the Policy, including, but not limited to, benefits paid in error by Physicians Plus, Physicians Plus can recover such excess benefit payments from any person, organization, Physician, Hospital or other health care Provider that has received such excess benefit payments. Physicians Plus can also recover such excess benefit payments from any other insurance company, service plan, governmental programs/plans or benefit plan that has received such excess benefit payments. If Physicians Plus cannot recover such excess benefit payments from any other source, We can recover such excess benefit payments from You. When We request that You pay Us an amount of the excess benefit payments, You agree to pay such amount immediately upon Our notification to You. Physicians Plus may, at Our option, reduce any future benefit payments for which We are liable under the Policy on other claims by the amount of the excess benefit payments, in order to recover such payments. Physicians Plus will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by Physicians Plus.

## **CLAIMS PROCEDURES (POST SERVICE)**

Benefits payable under the Policy will be paid as soon as reasonably possible after We receive the written proof of claim in accordance with the proof of claim provision. Claims will be processed and apply to any limits in the order they are received within a reasonable period of time after Physicians Plus receives the written proof of claim as describe in the proof of claim subsection of this section. Then we will decide whterh benefits are payable on the expenses for covered services submitted to Physicians Plus. Any benefits paid by Us in accordance with the Policy shall fully discharge Us from all further liability to the extent of benefits paid.

If benefits are payable on expenses for services covered under the Policy, Physicians Plus will pay such benefits directly to the Hospital, Physician or other health care Provider providing such services, unless You have already paid the expenses and submitted proof of payment to Physicians Plus before benefits are paid. If You have already paid the expenses and have submitted proof of payment to Us before benefits are paid to the provider, payment of such benefits will be made directly to You.

If there are circumstances that require Physicians Plus to have more time to determine Our liability to pay benefits on a claim, Physicians Plus will send You written notice within 30 days of Our receipt of the proof of claim, explaining why Physicians Plus needs more time to review the expenses. In that case, Our decision on the claim will then be made within 120 days of Our receipt of such proof of claim. An interest payment of 12% per year will be paid on claims not paid within 30 days of Our receipt of all information necessary for claim processing.

If benefits are denied, You will receive a written notice of the denial of such benefit including:

- (A) The specific reasons on which denial or partial denial is based; and
- (B) The specific references to the Policy provisions on which denial or partial denial is based; and
- (C) A description of additional material or information that may be necessary for You to perfect Your claim and an explanation of why such material or information is necessary; and
- (D) An explanation of how You may have the claim reviewed by Physicians Plus if You do not agree with Our denial or partial denial.

## **UNCONTROLLABLE CIRCUMSTANCES**

If circumstances beyond Our reasonable control delay or prevent the rendering of any covered treatment, service or supply by Participating Providers, Physicians Plus shall have no liability related to the delayed or prevented treatment, service or supply. Such circumstances may include war, terrorism, labor disputes, disability or other unavailability of a significant portion of Participating Providers, and other causes beyond Our reasonable control.

## 8. COORDINATION OF BENEFITS

---

This section applies to this Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. If this section applies, the order of benefit determination shall be established first according to the rules specified in order of benefit determination. The rules determine whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

- (A) Shall not be reduced when, under the rules specifying the order of benefit determination, this Plan determines its benefits before another Plan; but
- (B) May be reduced when, under the rules specifying the order of benefit determination, another Plan determines its benefits first. This reduction is described in Effect on the Benefits of this Plan.

Solely for purposes of this Coordination of Benefits section, "Plan" means any of the following that provide benefits or services for, or because of, medical or dental care or treatment:

- (A) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice, and individual practice coverage. It also includes coverage other than school accident-type coverage.
- (B) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (benefits under Title XIX of the Social Security Act of 1965, as amended.) It also does not include any Plan whose benefits, by law, are in excess of those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under (A) or (B) above is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, then each of the parts is a separate Plan.

Primary Plan/Secondary Plan: order of benefit determination state whether this Plan is a primary Plan or secondary Plan as to another plans covering the person.

When this Plan is a primary Plan, its benefits are determined before those of the other Plan, and without considering the other Plan's benefits.

When this Plan is a secondary Plan, its benefits are determined after those of the other Plan, and may be reduced because of the other Plan's benefits.

When there are more than two plans covering the person, this Plan may be a primary Plan as to one or more other plans and may be a secondary Plan as to a different Plan or Plans.

### **Order of Benefit Determination:**

- (A) General: When there is a basis for a claim under this Plan and another Plan, this Plan is a secondary Plan that has its benefits determined after those of the other Plan, unless:
  - (1) The other Plan has rules coordinating its benefits with those of this Plan; and
  - (2) Both those rules and this Plan's rules described in (B) below require that this Plan's benefits be determined before those of the other Plan.
- (B) Rules: This Plan determines its order of benefits using the first of the following rules that applies:
  - (1) Non-dependent/dependent: the benefits of the Plan that covers the person as an employee, Member or Subscriber (that is, other than as a dependent) are determined before those of the Plan that covers the person as a dependent.
  - (2) Dependent Child/Parents Not Separated or Divorced: Except as stated in (3) below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":

- (a) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar year are determined before those of the Plan of the parent whose birthday falls later in that Calendar year; but
- (b) If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

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

- (3) Dependent child/separated or divorced parents: If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - (a) First, the Plan of the parent with custody of the child;
  - (b) Then, the Plan of the spouse of the parent with custody of the child; and
  - (c) Finally, the Plan of the parent not having custody of the child.

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

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

- (4) Active/inactive employee: The benefits of a Plan that cover a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan that covers that person as a laid-off or retired employee or as that employee's dependent. If the other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (5) Continuation coverage: If a person has continuation coverage under federal law or Section 632.897 (3) (a), Wisconsin Statutes, and is also covered under another Plan, the following shall determine the order of benefits: 1) First, the benefits of a Plan covering the person as an employee, Member or Subscriber or as a dependent of an employee, Member or Subscriber; 2) The benefits under the continuation coverage.

If the plans do not agree on the order of benefits, this subdivision is ignored.

- (6) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, Member or Subscriber longer are determined before those of the Plan that covered that person for the shorter time.

If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the Plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this subsection.

## **EFFECT ON THE BENEFITS OF THIS PLAN**

When this subsection applies: This subsection applies when, in accordance with order of benefit determination subsection, this Plan is a secondary Plan as to one or more other plans. In that event, the benefits of this Plan may be reduced under this subsection. Such other Plan or other plans are referred to in this subsection as “other plans”.

Reduction in this Plan’s benefits: The benefits of this Plan will be reduced when the sum of:

The benefit that would be payable for the Allowable Expenses under this Plan in the absence of this section; and  
The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this section, whether or not claim is made, exceeds those allowable expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

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

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION:** Certain facts are needed to apply these COB rules. We have the right to decide which of these facts We need. We may get needed facts from or give them to any other organization or person. We need not tell or get the consent of any person to do this. Each person claiming benefits under this Plan must give Physicians Plus any facts We need to pay the claims.

## **FACILITY OF PAYMENT**

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

## **RIGHT OF RECOVERY**

If the amount of the payments made by Physicians Plus is more than We should have paid under this section, We may recover the excess from one or more of the following.

- (A) The persons We have paid or for whom We have paid;
- (B) Insurance companies; or
- (C) Other organizations.

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

## 9. DISENROLLMENT AND WHEN COVERAGE ENDS

---

Coverage under this Policy ends on the earliest of the following dates except as described in EXTENSION OF BENEFITS section of this Certificate:

- (A) The date the Policy terminates;
- (B) The date the Member dies;
- (C) The date the Member meets the lifetime benefit maximum for this Policy;
- (D) The last day of the calendar month for which the Member's premium contribution, if any, has been paid;
- (E) The date a Member enters into military service, other than for duty of less than 30 days;
- (F) If You're absent from work due to an Injury or Illness, the last day of the calendar month in which Your status as an employee ends as determined by his/her employer;
- (G) For an employee, the last day of the calendar month in which You cease to be within the class of employees eligible for coverage under the Policy;
- (H) For an employee's spouse and/or other dependent who is a Member, the date the employee's coverage terminates;
- (I) For the employee's spouse, the date the employee's spouse is no longer married to the employee due to divorce or annulment;
- (J) For the employee's Eligible Dependent child, stepchild, adopted child, or child Placed for Adoption with the employees to be eligible, the earliest of the following dates:
  - (1) The date the child marries;
  - (2) The date the child is eligible for coverage under a group health benefit plan that is offered by the child's employer and for which the amount of the child's premium contribution is not greater than the premium amount for his/her coverage as a dependent under this Policy;
  - (3) The date the Member or child meets the lifetime benefit maximum for this Policy;
  - (4) The end of the day (12:00/midnight) when the child exceeds the Maximum Dependent Age of 26.

However, there are two exceptions to coverage terminating when the dependent child exceeds the Maximum Dependent Age, if the child otherwise satisfies the coverage requirements.

First, coverage for the child will not terminate if a child, who otherwise satisfies the coverage requirements, is and continues to be both: (i) incapable of self sustaining employment because of mental or physical handicap and (ii) chiefly dependent upon the covered employee for support and maintenance, may remain eligible under Family Coverage beyond the Maximum Dependent age. Physicians Plus will work with the employee, the dependent child and the Attending Physician to establish the child's mental or physical handicap. Physicians Plus will make the final decision regarding the eligibility of the child. Eligibility will be verified annually.

Second, coverage may continue for a child who is and remains a Full-Time Student and is eligible for coverage as Full-Time Student after being called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces (see "EFFECTIVE DATES AND ELIGIBILITY" section of this Certificate).

- (L) For the grandchild of the covered employee the date that the grandchild's parent reaches age 18 or otherwise loses coverage;
- (M) The date a Member is disenrolled as described in any section of this Policy; and
- (N) For a child that is Placed(Placement) for Adoption with the employee but for whom the adoption is not finalized, the date when the child's adoptive placement with the Subscriber is terminated.

## **DISENROLLMENT PROVISION**

We may terminate a Member's coverage and disenroll such Member from Physicians Plus coverage for any of the following reasons:

- (A) The Member has failed to pay required premium by the end of the grace period;
- (B) The Member has reached the Policy lifetime limits;
- (C) The Member has committed acts of physical or verbal abuse that pose a threat to Providers or other Physicians Plus Members;
- (D) The Member has improperly allowed a person other than a Member to use a Physicians Plus identification card to obtain services or has knowingly provided fraudulent information in applying for coverage;
- (E) The Member is unable to establish or maintain a satisfactory physician-patient relationship with the Member's PCP; or
- (F) Physicians Plus has not renewed the Policy; or
- (G) The Member establishes residence outside of the Service Area.

Disenrollment for reason (E) shall occur only after We have provided the Member with the opportunity to select an alternate PCP, made a reasonable effort to assist the Member in establishing a satisfactory physician-patient relationship and told the Member that a Grievance may be filed on this matter. If a Member is disenrolled for reasons (C), (D), (E) coverage shall continue until the Member finds other coverage or until the next opportunity for the Member to change insurers, whichever comes first.

## 10. CONTINUATION OF COVERAGE

---

Continuation of coverage is offered by the Policy holder and/or the employer group. If You are on a group (employer sponsored) Plan and You have questions related to continuation coverage and/or eligibility please contact Your employer. Continuation coverage does not apply to individual coverage or coverage NOT provided by an employer.

### WISCONSIN LAW - GENERAL RULE

#### WISCONSIN CONTINUATION

In certain cases a Member may be eligible to continue terminated coverage that would otherwise end under general provisions. Those eligible for continuation of coverage are:

- (A) A Subscriber who is no longer eligible under the Policy, except if employment is terminated for misconduct on the job; or
- (B) A Subscriber's spouse or dependent who is no longer eligible under the Policy due to divorce, annulment or death of the Subscriber.

In either case, the Member must have been covered under the Policy for at least three months prior to the termination date of coverage.

Within five days of receiving notice to end a Member's coverage, the Policyholder must notify the Member of:

- (A) The option to continue coverage under this provision or convert coverage as provided under conversion Policy provisions;
- (B) The premium amount the Member must pay monthly to continue coverage or purchase the conversion Policy;
- (C) The manner in which and the place to which the Member must make premium payments; and
- (D) The time by which the Member must pay for continuation of coverage.

Continuation of coverage under the Policy may be continued until the earliest of the following dates:

- (A) The date the Member becomes eligible for other similar group coverage;
- (B) For a Member spouse who originally obtained coverage through his/her former spouse, the date his/her former spouse is no longer eligible for coverage under the Policy;
- (C) The date the Policy terminates;
- (D) The date the Member moves out of Wisconsin;
- (E) The end of the period of time for which the Member timely paid premium; or
- (F) The end of 18 months after the Member elects continuation of coverage.

A Member may convert to an individual medical expense conversion Policy when continuation of coverage ends unless continuation of coverage ends because of nonpayment of premium to Us as required (see conversion Policy provision).

**SPECIAL WISCONSIN RULE FOR DEPENDENT'S MEDICALLY NECESSARY LEAVE OF ABSENCE FROM SCHOOL** – this section only applies when the Covered Dependent had coverage beyond the Maximum Dependent Age as a Full-Time Student after being called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces (see "EFFECTIVE DATES AND ELIGIBILITY" section of this Certificate).

A dependent who was covered as a Full-Time Student shall continue to be eligible for coverage if, due to a medically necessary leave of absence, he/she ceases to be a Full-Time Student.

A dependent is only eligible for this special continuation of coverage if he/she notifies Us within thirty (30) days of ceasing to be a Full-Time Student and submits documentation and certification to us of the medical necessity of the leave of absence from his/her Attending Physician. The date the dependent ceases to be a Full-Time Student due to the medically necessary leave of absence shall be the date on which this special continuation coverage begins.

This special continuation coverage ends when any of the following happen:

1. The dependent advises Us that he or she does not intend to return to school full time.
2. The dependent becomes employed full time.
3. The dependent obtains other health care coverage.
4. The dependent marries and is eligible for coverage under his or her spouse's health care coverage.
5. Coverage of the Subscriber through whom the person has dependent coverage under the policy is discontinued or not renewed.
6. One year has elapsed since the dependent's special continuation coverage under this provision began and the dependent has not returned to school full time.

## **FEDERAL LAWS**

### COBRA

A Member who is no longer eligible for coverage under the Policy, such as former employees, certain dependent children and divorced or surviving spouses and their dependent children may be eligible for continuation of coverage in accordance with the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as amended. To the extent COBRA applies to a Policyholder or Member, the following provisions apply:

COBRA requires a Member to notify the Policyholder of a divorce or legal separation, the date on which a child ceases to be an Eligible Dependent, that would cause a loss of coverage and within 60 days of such event. The Policyholder then has 14 days to notify the Member of the right to elect coverage under COBRA.

The Policyholder must notify Physicians Plus within 30 days of a Subscriber's death, termination, reduction in hours of employment, entitlement to Medicare or the Policyholder's initiation of bankruptcy proceedings. Failure to comply with any of these required notice periods may result in a Member's ineligibility for COBRA coverage.

COBRA coverage is available for limited periods of time, which vary according to the Member's status and the particular circumstances that resulted in loss of eligibility for coverage. Despite these time limits, COBRA coverage will cease when:

- (A) the Member becomes covered under any other group Plan that has no exclusion for Pre-Existing conditions of the Member; or
- (B) the Member becomes entitled to Medicare;
- (C) premiums are no paid on a timely basis; or
- (D) the Policyholder ceases to maintain any group health Plan.

The Member is required to notify the Policyholder if either event (A) or (B) occurs while the Member has COBRA coverage.

### USERRA

The federal Uniformed Services Employment and Reemployment Rights Act, as amended (USERRA), also grants continuation rights to employees who leave their employment to perform military service. Those Members may be eligible to elect to continue their group coverage for themselves and their dependents for up to 24 months.

If properly elected, the USERRA continuation coverage begins on the date when the employee's absence from work for the purpose of performing military service begins. If the Member performs military service for fewer than 31 days, he/she cannot be required to pay more than the regular employee share, if any, for the group coverage. If the Member performs military service for 31 or more days, he/she can be required to pay no more than 102% of the full premium under the Plan.

If You will be leaving Your employment in order to perform military service, please see Your employer for information on electing to continue Your group health coverage.

## **IN AREA CONVERSION POLICY PROVISION**

After coverage ends as described in the WHEN COVERAGE ENDS AND DISENROLLMENT provision, or at the end of Wisconsin or COBRA continuation of coverage as described in CONTINUATION OF COVERAGE, a Member may be eligible to purchase the type of individual medical expense conversion Policy that Physicians Plus makes available to eligible Members.

To obtain the conversion Policy, the conversion coverage must be required under COBRA or Wisconsin Law, and the Member must apply to Physicians Plus and pay the required premiums to Physicians Plus. The Member must do this within 30 days of the Policyholder notifying the Member of his/her right to conversion coverage. If the Member applies and pays within the 30-day period, the conversion Policy will cover the Member as of the date coverage under the group policy ends.

To obtain information on the plans offered by Physicians Plus please contact Our Member Service department at (608) 282-8900 or (800) 545-5015.

## 11. EXTENSION OF BENEFITS

---

On the date the Policy ends for all group Members, benefits will continue for each Member who, as determined by Physicians Plus, is either a Totally Disabled Subscriber or a Totally Disabled dependent of a Subscriber on the date the Policy ends.

This extension of benefits continues only for benefits for the disabling conditions and shall end on the earliest of the following dates:

- (A) The date the Member is no longer Totally Disabled as determined by Physicians Plus;
- (B) The date on which 12 consecutive months have passed since the date the Policy ended;
- (C) The date the Member exhausts the maximum benefit period or benefit limit under the Policy; or
- (D) The date on which coverage for the condition(s) causing the Member's Total Disability is provided under similar coverage, other than temporary coverage required by s. Ins 6.51 (7m) (b)2, Wisconsin Administrative Code, under another group health Plan.

The extension of benefits does not provide coverage for dental services or uncomplicated pregnancies or for any Injury or Illness other than the condition(s) causing the Member's Total Disability.

**Totally Disabled/Total Disability** means the Member's inability, due to Illness or Injury, to perform the functions or duties of his/her job for the Policyholder or of any job for pay or profit, as determined by Physicians Plus. If a Member does not have a regular occupation, Totally Disabled or Total Disability means the Member's inability, due to Illness or Injury, to substantially engage in normal activities of a person of the same age and sex, as determined by Physicians Plus. The Member must be under the regular care of a Physician for the disability. Physicians Plus has the right to examine such Member as is reasonably necessary to establish Total Disability.

## 12. APPEAL PROCESS

---

The Physicians Plus appeal process encompasses all levels of appeal including, but not limited to, Complaints, Grievances, and Independent review.

### COMPLAINT

Situations might occasionally arise when You question or are unhappy with some aspect of the service You received through Physicians Plus. Since most questions about benefits and Plan operations can normally be resolved on an informal basis, We encourage You to first try and resolve the problem with the appropriate Physician, staff member or by calling Our Member Service department at (608) 282-8900 or (800) 545-5015. Your Complaint will be documented and investigated. If Your Complaint is not resolved to Your satisfaction, You or a representative may file a Grievance with Physicians Plus.

### GRIEVANCE PROCESS

A Grievance is any dissatisfaction with services provided by, or claims practices of, Physicians Plus that is expressed in writing to Physicians Plus by or on behalf of You. If You want to submit a Grievance, please submit it in writing, along with any pertinent documentation, to:

Physicians Plus Insurance Corporation  
Attn: Grievance Administrator  
22 East Mifflin Street, Suite 200  
PO Box 2078  
Madison, WI 53701-2078

Except for an expedited Grievance (described below), Physicians Plus will acknowledge receipt of Your Grievance within five business days of receipt. We also will notify You in writing of the time and place when Your Grievance will be heard by the Grievance Committee (which will be at least seven days after the date of Our notification to you).

Except for an expedited Grievance (described below), You (or an authorized representative) will have the right to participate in the Grievance Committee meeting or attend by teleconference to present written or oral information. If You choose to participate (or have Your authorized representative participate) in the Grievance Committee hearing, You must notify Physicians Plus no less than four business days prior to the date of the hearing.

Typically within 30 days of Our receipt of Your Grievance, Physicians Plus will notify You in writing of the decision made by the Physicians Plus Grievance Committee. In some situations Physicians Plus may need additional information and/or time to make a decision. In those cases, Physicians Plus will notify You that an additional 30 calendar days will be needed to render a decision. The Grievance Committee's decision will inform You of the disposition of Your Grievance and of any corrective action taken on Your Grievance.

If a person is acting as Your authorized representative in the Grievance process, Physicians Plus may require written evidence of the representative's authority to act on Your behalf.

## **EXPEDITED GRIEVANCE**

If You have an "expedited Grievance," Physicians Plus will resolve that Grievance as expeditiously as Your health condition requires but not later than 72 hours after Physicians Plus' receipt of the Grievance. An "expedited Grievance" means a Grievance where any of the following applies:

1. The duration of the standard Grievance process will result in serious jeopardy to Your life or health or Your ability to regain maximum function;
2. In the opinion of a Physician with knowledge of Your medical condition, You are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance; or
3. A Physician with knowledge of Your medical condition determines that the Grievance shall be treated as an expedited Grievance.

When You need to request review of an expedited Grievance: (a) prominently identify Your written Grievance as an "EXPEDITED GRIEVANCE" and (b) immediately contact (or have Your Physician immediately contact) Physicians Plus at (608) 282-8900 or (800) 545-5015.

## **INDEPENDENT REVIEW PROCESS**

### **What is an independent review?**

The independent review process gives You the opportunity to have peer review professionals that have no connection to Physicians Plus review a decision or dispute of an Adverse Determination, Experimental Treatment Determination a Pre-existing Condition denial determination or the rescission of your policy. For multiple family Member disputes, each Member must meet the criteria and submit the necessary fees. The dispute must involve an Adverse Determination or Experimental Treatment Determination made by Physicians Plus.

This includes denials of coverage for treatment because We maintain that the treatment is not medically necessary or that it is Experimental, and a denial of Your request for out-of-network services when You believe that the clinical expertise of the out-of-network Provider is medically necessary. The treatment must otherwise be a covered benefit under Your insurance Policy. Also, the total cost of the denied coverage must exceed \$296.00 (this dollar amount is set by the Office of the Commissioner of Insurance annually).

You or Your authorized representative must request an Independent review within 4 months from the date of the adverse determination, Experimental treatment determination, Pre-existing Condition denial or rescission of your policy decision made by Physicians Plus or 4 months from the date of receipt of the Grievance Committees decision, whichever is later.

You will choose the Independent Review Organization (“IRO”) from a list of review organizations certified by the Office of the Commissioner of Insurance for the State of Wisconsin (“OCI”) see the list of IRO’s on Our website at [www.pplusic.com](http://www.pplusic.com) or OCI’s website at [www.oci.wi.gov](http://www.oci.wi.gov). If You do not have access to these websites You may contact Physicians Plus for a current IRO listing.

The IRO assigns Your dispute to a reviewer who is an expert in the treatment of Your medical condition/situation. The IRO has the authority to determine whether Physicians Plus should cover the treatment and/or services. Pursuant to Section 632.835(3)(f) of the Wisconsin Statutes, the IRO’s decision is final and binding on You and Physicians Plus for Adverse Determination and Experimental Treatment Determinations.

“Adverse Determination” means a determination by or on behalf of Physicians Plus to which all of the following apply:

1. An admission to a health care facility, the availability of care, the continued stay, or a treatment that is a covered benefit has been reviewed and denied;
2. Based on the information provided, We have determined that the treatment or care does not meet the requirements of Your health benefit Plan for medical necessity, medical appropriateness, proper health care setting, level of care, or effectiveness of care;
3. Based on the information provided, We reduced, denied, or terminated the treatment or care or the payment for the treatment or care;
4. The amount of the reduction or the cost or expected cost of the denied or terminated treatment or care, or course of treatment or care will exceed \$296.00; and
5. The reduction, denial or termination has been through all levels of the Physicians Plus Grievance Process, except if the criteria for an Expedited Independent Review is satisfied (see "Expedited Independent Review" below).

Experimental Treatment Determination means a determination by or on behalf of Physicians Plus to which all of the following criteria apply:

1. A proposed treatment has been reviewed;
2. Based on the information provided, the proposed treatment is determined to be Experimental according to the terms of Your health benefit Plan;
3. Based on the information provided, We denied the proposed treatment or payment for the proposed treatment;
4. The cost or the expected cost of the denied treatment or payment will exceed \$296.00; and
5. The denial of the proposed treatment has been through all levels of the Physicians Plus Grievance Process, except if the criteria for an Expedited Independent Review is satisfied (see "Expedited Independent Review" below).

### **When can I request an independent review?**

When We make an Adverse Determination, Experimental Treatment Determination a Pre-existing Condition denial determination or the rescission of your policy and the cost of the combine denied service exceeds \$296.00, You are entitled to an independent review. You or Your authorized representative must request an Independent review within 4 months from the date of our decision of the Adverse Determination, Experimental Treatment Determination a Pre-existing Condition denial determination or the rescission of your policy or 4 months from the date of receipt of the Grievance Committee’s decision, whichever is later.

**Please Note: Expedited Independent Review**-You may qualify for an expedited independent review if You meet the following criteria. Under Section 632.835(2)(d) of the Wisconsin Statutes, if either of the following conditions applies, You will not have to exhaust the Physicians Plus Grievance process before You are entitled to the independent review process:

1. You (or Your authorized representative) and Physicians Plus agree that the appeal should proceed directly to independent review; or
2. You provide Us with a written request for independent review and You submit to the IRO selected by You a request to bypass our Grievance process and the IRO determines that Your health condition is such that requiring You to first complete the Physicians Plus Grievance Process would jeopardize Your life or health or Your ability to regain maximum function.

If You wish to request an Expedited Independent Review, You should submit Your request to the IRO selected by You, and You must send a notice of Your request to Physicians Plus at the same time.

### **How do I request an independent review?**

When requesting an independent review, You or Your authorized representative(s) must send to Physicians Plus a written request for the independent review. You or Your authorized representative must request an independent review within 4 months from the date of the Adverse Determination, Experimental Treatment Determination a Pre-existing Condition denial determination or the rescission of your policy decision made by Physicians Plus or 4 months from the date of receipt of the Grievance Committee's decision, whichever is later. Your request must be in writing and must:

1. Identify Your name and Member number, dates of service, Provider of service and any other pertinent information used to identify the issue;
2. Identify the name and address of the IRO that You have selected (a list of review organizations, certified by OCI, is available on line at [www.pplusic.com](http://www.pplusic.com) or from OCI at [www.oci.wi.gov](http://www.oci.wi.gov); and

The IRO will make a determination within 30 days (or, in the case of an Expedited Independent Review, within 72 hours of receiving all information it needs) and notify the Member and Physicians Plus. If the IRO determines that the review is not related to an Adverse Determination or Experimental Treatment, the IRO will provide the Member, Physicians Plus, and OCI with written notification within two days of receiving the request for review.

## **OFFICE OF THE COMMISSIONER OF INSURANCE**

You may resolve Your concern by taking the steps outlined above. You may also contact the Office of the Commissioner of Insurance, a state agency that enforces Wisconsin's insurance laws, and file a Complaint. You may contact the Office of the Commissioner of Insurance by writing to:

Office of the Commissioner of Insurance  
Complaints Department  
121 E. Wilson Street  
PO Box 7873  
Madison, WI 53707-7873

You may call (608) 266-0103 in Madison or (800) 236-8517 outside of Madison to request a Complaint form.

**EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA):** ERISA does not apply to State, ETF or Non-Group plans including Medicare Supplement policies.

You also may have a right to bring a civil action under ERISA 502(a) if You timely file an appeal and Your request for coverage or benefits is denied in the appeal process. Your appeals must be filed with Us no more than 180 days from the date of our initial denial. Please contact Your EMPLOYER for more information on Your rights under ERISA (ERISA does not apply to State, ETF or Non-Group plans including Medicare Supplement policies).

## 13. PRIVACY AND CONFIDENTIALITY

---

This section of the Certificate contains the Physicians Plus Notice of Privacy and Confidentiality practices in simple terms. This section includes:

- Notice of Privacy and Confidentiality practices; and
- Gramm-Leach Bliley Act of 1999; and
- An EXAMPLE of an Acceptance Agreement (in most cases signed at enrollment by Members).

We may update information regarding the Privacy Practices of Physicians Plus as changes in the law or Our practices occur. We will update and/or distribute changes as required by law. You may also visit Our website for more information on the Privacy Practices of Physicians Plus at [www.pplusic.com](http://www.pplusic.com). If You have questions please contact Our Privacy Officer at (608) 282-8900 or (800) 545-5015.

### **Notice of Physicians Plus Insurance Corporation Privacy and Confidentiality Practices** @ September 2009

You do not have to act on this Notice; it is for informational purposes only. This Notice describes how medical information about you and your family may be used and how you can get access to this information. Please review this notice carefully. If you have any questions about this notice, please contact the Physicians Plus Privacy Officer at (800) 545-5015 or (608) 282-8900.

#### PHYSICIANS PLUS' PLEDGE REGARDING MEDICAL INFORMATION:

Physicians Plus understands and respects the privacy of your medical information. Physicians Plus is required by law to maintain the privacy of "protected health information." Protected health information is information that may identify you and that relates to your past, present or future medical condition including care and payment for care. Physicians Plus keeps your information private and safe by following and exceeding state and federal law to ensure the protection of your health information.

Physicians Plus is required to:

- Keep safe protected health information and provide you with certain rights to comply with state and federal law;
- Give you this notice of our legal duties and privacy practices with respect to your protected health information; and
- Abide by the terms of this notice that is currently in effect.

This notice will inform you about the ways Physicians Plus may use and release medical information about you and your dependents. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your protected health information.

#### **HOW PHYSICIANS PLUS MAY USE AND RELEASE PROTECTED HEALTH INFORMATION**

Under law, Physicians Plus may use and release protected health information without your authorization in certain cases in order to provide you with health-related services. The following examples show how protected health information is used and released by Physicians Plus for this purpose (this is not an all-inclusive list and not every type of use or reason to release information is in a category is listed):

**Payment** Physicians Plus may use and release protected health information for payment of your health and pharmacy claims. We may use and release protected health information for purposes of billing, claims payment, determinations of eligibility and coverage for health benefits. For example, in order to pay for your health care services or treatment,

Physicians Plus will receive and review claims for services sent to us by your health care providers. We may also use and release protected health information to determine the medical necessity of certain treatments. For example, we may review your protected health information to determine whether a specific medical procedure is appropriate and consistent with your health condition.

**Health Care Operations** Physicians Plus may use and release protected health information for health care operations. For example, health care operations include long term illness management activities, quality assessment activities, legal services and credentialing and review of physicians who provide care for our members. We may also use and release your protected health information for certain internal marketing activities. For example, your name, address or e-mail address may be used to send you a newsletter. You may contact our Privacy Officer to request that these materials not be sent to you. Physicians Plus may also use protected health information to contact you regarding health promotion and disease prevention. For example, we might send reminders regarding follow-up appointments, examinations, pre-natal and post-natal screenings, counseling on nutrition and exercise, immunization reminders and recommendations regarding heart health, cancer prevention and diabetes health management and other specific health and long term illness management programs. We may also use and release protected health information received at the time of enrollment for underwriting and determining premiums and addressing questions about our insurance products.

**Business Associates** Physicians Plus may contract with entities known as Business Associates to perform various functions and provide certain services on our behalf. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or release protected health information, but only after they agree in writing to implement proper safeguards regarding protected health information. For example, we may release protected health information to a Business Associate to perform claims administration services, legal services or pharmacy management services, but any such Business Associate must agree in writing to safeguard protected health information.

## **OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

The following describe other ways in which Physicians Plus may use and release protected health information without authorization:

**As Required By Law** We may use or release protected health information as required by law so long as the use or release complies with applicable law.

**Legal Proceedings** We may use or release protected health information in the course of any legal proceedings. Physicians Plus may release protected health information in response to a court or administrative order. We may also release protected health information in response to a subpoena, discovery request or other lawful process, so long as such disclosure complies with applicable law.

**Law Enforcement** We may release protected health information for law enforcement purposes pursuant to process and as otherwise required by law. Physicians Plus may also release protected health information in regard to the following situations: identifying or locating suspects, fugitives, material witnesses or missing persons; in regard to suspected victims of crimes; in regard to a death that may have resulted from criminal conduct; or in regard to possible crimes on our premises.

**Worker's Compensation** We may use or release protected health information to comply with worker's compensation laws or similar programs.

**Disclosures to Benefit Plan Sponsors/Employers** Physicians Plus may release health-related information to employers who sponsor group health plans for various purposes. For example, we may release summary health information to employers in regard to obtaining premium bids or modifying or terminating a group health plan. We may also release enrollment and termination information to employers, including information relating to deductibles, premiums,

Medicare and COBRA status We may release protected health information to employers for group health plan administrative functions, such as administering a wellness or other employer-sponsored plan or program. For example, where an employer-sponsored wellness plan provides a benefit to employees who have an annual check up, we may verify the completion and date of such check up. In all such instances of disclosing health-related information to employers, we will release the minimum necessary to accomplish the intended purpose of the request.

**Health Oversight Activities** We may release your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Research** We may release your protected health information to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

## **DISCLOSURES WITH YOUR AGREEMENT OR OPPORTUNITY TO OBJECT**

**Individuals Involved in Your Care** Unless you object, Physicians Plus may release to a family member, relative, close friend or anyone you identify your protected health information that directly relates to that person's involvement in your health care or payment for your health care. For example, we may communicate with your spouse regarding payment of a bill, so long as you have not requested that such information remain confidential. In such situations, the minimum amount of information necessary to address the issue will be used or released. If you are unable to agree or object to our communications with your family or friends, we will determine whether disclosure of protected health information is in your best interest, using our best professional judgment.

## **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by applicable laws or this notice will be made only with your written authorization. If you provide authorization for the use or disclosure of protected health information, you may cancel the authorization, in writing, at any time. If you cancel the authorization, we will not use or release your protected health information for the reasons covered by your written authorization from the time of your request and forward. However, the cancellation will not apply to uses or disclosures made prior to the cancellation in accordance with the authorization.

## **YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

The following are your rights regarding your protected health information. As you review these rights, please keep in mind that Physicians Plus does not keep your medical records. To make requests or ask questions about any of these rights, please write Physicians Plus at:

Physicians Plus Insurance Corporation  
Attn: Privacy Officer  
22 E. Mifflin Street, Suite 200                      or                      ppinfo@pplusic.com  
Madison, WI 53703

**Right to Inspect and Copy Protected Health Information** You have the right to inspect and get a copy of protected health information that may be used to make decisions about your health care benefits. To inspect or copy your protected health information, you must submit a written request to the address above. Under law, certain types of protected health information is not available for inspection or copying, including psychotherapy notes, information compiled in reasonable anticipation of, or use in, any civil, criminal or administrative claim or legal proceeding, or other information subject to laws that prohibit access. If we deny access to certain protected health information, you may request a review of the decision by writing to the address listed above.

**Right to Amend** If you believe that any of your information is incorrect or incomplete, you may ask to have that information amended. You have the right to request an amendment to medical information for as long as the information is maintained. To request an amendment, you must submit your written request, including the reasons that support your requested amendment(s). Physicians Plus will respond to your request in writing within 30 days of receipt and will provide you with more information about your rights in the event we allow or deny your request to amend.

**Right to an Accounting of Disclosures** You have the right to receive a written report of certain disclosures we make of your protected health information. The report would not include disclosures made for payment or health care operations as described in this notice. The report would also exclude disclosures made to you or family members or friends involved in your care or disclosures made according to your signed authorization. The report would include a list of persons or entities to whom information was released, a short description of the information released and the purpose for the disclosure. For information about requesting an accounting of disclosures, please write to the address listed above.

**Right to Request Restrictions and Confidential Communications** You have the right to request certain restrictions or limitations on the use of protected health information for treatment, payment or health care operations, or that we release to someone who may be involved in your care or payment for your care, like a family member or friend. If you would like more information about your rights on requesting restrictions please contact us at the address listed above. Please note that we are not required to agree to your requested restrictions. You also have the right to request that we communicate with you about protected health information by certain means or at a certain location.

We will accommodate such requests to the best of our ability. To request confidential communication changes, you must submit your request in writing to the above address. We may refuse to accommodate your request if you have not provided information as to how payment, if applicable, will be handled or do not specify how or where you wish to be contacted.

**Right to Paper Copy of This Notice** You have the right to a paper copy of this notice. You may ask for a copy at any time. Even if you agree to receive this notice electronically, you may still request a paper copy of the notice. To obtain a paper copy of this notice, call or write us, or download it from our website at [www.pplusic.com](http://www.pplusic.com).

## **CHANGES TO THIS NOTICE**

We reserve the right to make changes to this notice. If we make significant changes to the notice, we will send it to you within 60 days of the revision. The notice will contain the new effective date in the upper right-hand corner.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a privacy complaint with Physicians Plus or with the Secretary of the Department of Health and Human Services. To file a privacy complaint with Physicians Plus, contact the Privacy Officer at the address listed above. Please note that all other complaints unrelated to privacy must follow the procedures outlined in your Policy or Medical Certificate of Coverage. We will not treat you differently in any way for filing a complaint.

## **GRAMM-LEACH-BLILEY ACT AND WISCONSIN ADMINISTRATIVE CODE INS 25**

In the process of providing You with health insurance, Physicians Plus may obtain certain personal financial information about You, legally named "nonpublic personal financial information." The Gramm-Leach-Bliley Act of 1999 and Wisconsin Administrative Code INS 25 require Us to take steps to protect the confidentiality of Your nonpublic personal financial information.

To comply, We are providing You with this notice of Our privacy policies and practices regarding nonpublic personal financial information. To the extent that federal and state law differs, We will comply with the requirements of the stricter law.

We obtain nonpublic personal financial information about You from the following sources:

- Information We receive from You on applications or other forms;
- Information about Your transactions with Physicians Plus, Our affiliates or others.

Disclosure of nonpublic personal financial information:

- We do not disclose nonpublic personal financial information about Our customers or former customers to affiliates or non-affiliated parties, as applicable, except as permitted by law.

Our policies and practices regarding the confidentiality and security of nonpublic personal financial information include:

- We restrict access to nonpublic personal financial information about You to those who need to know that information in order to provide products or services to You.
- We maintain physical, electronic and procedural safeguards that comply with federal and/or state regulations to guard Your nonpublic personal financial information.
- We do not sell Member lists containing nonpublic personal financial information. In connection with the potential sale or transfer of Our business interests, ownership, business or business lines, Physicians Plus reserves the right to sell or transfer Your information (including but not limited to Your address, name, age, sex, zip code, state and country of residency and other information that You provide through other communications) to a third party entity that (1) concentrates its business in a similar practice or service; (2) agrees to be Physicians Plus's successor in interests with regard to the maintenance and protection of the information collected; and (3) agrees to the obligations of this privacy statement.
- We reserve the right to amend, modify or change at any time and for any reason, Our privacy policies and this notice. In any such event, We will provide You with an amended notice.

### **ACCEPTANCE/AGREEMENT - EXAMPLE ONLY**

This is an example of the acceptance agreement normally signed by a Member at the time of application. By signing this application, I understand and agree that: a) All statements and answers I've given are complete and true to the best of my knowledge and belief; b) The insurance I hereby apply for will be effective only when Physicians Plus Insurance Corporation (Physicians Plus) approves this application. Evidence of such approval will be issuance of the Medical Certificate in accordance with the Group Master Policy; c) I hereby designate the group Policyholder to be my remitting agent; d) I authorize the use of a Social Security Number for purpose of identification.

I understand that my employer, not Physicians Plus, represents me, my spouse and my legal dependents and my employer acts as my / Our sole agent for any and all purposes. I understand that any insurance agent, broker or my employer cannot modify, waive or change in any way this application, any requirement imposed by Physicians Plus, bind coverage or guarantee approval of this application. I further understand and agree that Physicians Plus, its directors, officers, employees and agents shall not be liable for any Injury, damage or expense (including attorneys' fees), I, and / or my spouse and / or any of my dependent(s) suffers as a result of any improper advice, action or omission on the part of any health care Provider.

Authorization to Obtain and Release Medical Information

By my (Our) signature on this application, I (We) authorize: (1) any Physician, medical practitioner, Hospital, clinic, medically-related facility or other institution who provided treatment or service to me, my spouse and / or my legal dependent(s) listed on the front of this form (to the extent permitted by law) at any time, or their agent(s) (including billing service), having medical information that includes, but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and / or services, test results (excluding any HIV antibody test or genetic test results, but including x-rays) or summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of Injury or Illness (including pregnancy) and treatment or service, if any, for mental or nervous conditions (excluding psychotherapy notes as defined by law), alcohol or drug abuse, including all programs in which the patient has been enrolled as an alcohol or drug abuse patient; and (2) any insurance or reinsuring company, service or prepaid benefit Plan, Plan administrator, consumer reporting agency, employer or personal or business associate having non-medical information about me, my spouse and / or my minor child(ren); to disclose to Physicians Plus or their representative(s) (including claims and underwriting departments) all such information (including photographic copies thereof).

I understand that said information will be used by Physicians Plus to determine eligibility for coverage, evaluate and audit claims and determine availability of benefits under the Physicians Plus group health insurance Policy, benefit Plan or other contract, if issued by Physicians Plus to my employer. I agree that Physicians Plus may release said information to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claim(s) or the claim(s) of my spouse and / or my dependent(s) or as may be otherwise permitted by law or as I may further authorize from time to time.

I further authorize Physicians Plus at its option to furnish and deliver to my employer and/or group Policyholder or its representative(s) in accordance with the Physicians Plus group health insurance Policy, non-identifying personal health information related to the cost of treatments and/or services, payment(s) made for treatments and/or services, dates of said payment(s), and recipients of said payment(s). I understand that the purpose and / or need for such disclosure is for said person(s) to promote health and wellness within the group Policy, evaluation of Policy premium fluctuation, utilization management and / or the transfer of claims administration.

I understand that I will receive a copy of this authorization. I understand that I have the right to inspect or copy the personal health information to be used or disclosed by Physicians Plus. I understand that this authorization is revocable upon advance written notice given to Physicians Plus at its office in Madison, Wisconsin, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and Physicians Plus and its directors, officers, employees and agents shall not be held responsible or liable for such release.

I understand that Physicians Plus may not condition treatment, payment, enrollment or eligibility for benefits on the provision of this authorization. I also understand that I may refuse to sign this authorization however in doing so, Physicians Plus may condition payment of claims and services as permitted by law. I understand that this authorization will remain valid for up to thirty months from the date I or my legal representative execute this authorization or, if longer and permitted by law, for so long as the Policy is in force under Physicians Plus. I further understand that a photographic copy of this authorization is as valid as the original.

I understand that I may obtain a detailed description of Physicians Plus' Notice of Privacy Practices from the Member Certificate, on the Physicians Plus Web site or I may obtain a copy by contacting Physicians Plus Insurance Corporation directly.

Signature of this Agreement does not authorize the use or disclosure of information, which is prohibited under Section 631.90 Wisconsin Statutes as it relates to provisions concerning HIV or the use or disclosure of information, which is prohibited under Section 631.89 Wisconsin Statutes as it relates to genetic tests.

## 14. DEFINITIONS

---

**Actively at Work** means when the Subscriber is performing the duties of his/her job with the Policyholder for at least the minimum number of hours per week as required on the Policyholder's current application for coverage. The Subscriber will be considered to be actively at work on:

- (A) Each day of a paid vacation; or
- (B) A regularly scheduled non-working day provided that, in either case, the Subscriber was at work on his/her last regular working day prior to that date.

**Activities of Daily Living** means the following, with or without assistance:

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

**Acute:** Referring to symptoms of abrupt onset, often of marked severity or intensity.

**Allowed Amount/Allowable Expense:** a necessary, reasonable and customary expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an allowable expense and a benefit paid. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the Plan.

**Ambulatory Surgery Center** means a licensed freestanding or Hospital-based outpatient center/facility providing services for surgical and medical diagnosis.

**Amount Billed/Billed Charges** means the amount that a Provider lists on its bill for a treatment, service or supply. A Provider's Billed Charge may be greater than the "Covered Charge". Physicians Plus may pay the Provider on a basis other than the Provider's Billed Charge. See the DEDUCTIBLE, COINSURANCE, COPAYMENTS and MAXIMUMS section of this Certificate for more information.

**AODA Services** means services for alcohol or drug abuse.

**Attending Physician** means a licensed medical doctor who coordinates a Member's care in connection with an Injury or an episode of Illness.

**Behavioral Health** includes nervous or mental disorders.

**Benefit Maximum** means the maximum amount that we will pay for a specific benefit during the Contract Year that you are covered under this Policy. When a Benefit Maximum applies, it is described in your Schedule of Benefits.

**Billed Charge** means the amount that a Provider lists on its bill for a treatment, service or supply. A Provider's Billed Charge may be greater than the "Covered Charge". Physicians Plus may pay the Provider on a basis other than the Provider's Billed Charge. See the DEDUCTIBLE, COINSURANCE, COPAYMENTS and MAXIMUMS section of this Certificate for more information.

**Biopharmaceutical Drugs** means drugs manufactured through advanced technologies including biotechnology methods involving live organisms or derived functional components (bioprocessing) approved and regulated under the FDA's Center for Drug Evaluation and Research (CDER) intended for the prevention, treatment or cure of disease/condition in human beings.

**Calendar Year** means the period of January 1st of any year and ending on December 31st of that same year.

**Certificate or Medical Certificate of Coverage** means this document issued by Physicians Plus to the Subscriber covered under the Policy. It is not a contract of insurance, but only evidence of coverage, and describes the benefits provided by the Policy.

**Charge** means the amount that the Provider has agreed to accept as payment in full for a treatment, service or supply. This amount includes any Deductible, Coinsurance, Copayments and maximums the Member is obligated to pay under the Policy. The "Charge" may be different than the Provider's "Billed Charges", "Covered Charge" or the "Usual and Customary charges". Charges for Hospital or other institutional confinements are considered to be incurred on the date the treatment, service or supply was provided. The benefit levels that apply on the Hospital admission date apply to the charges incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.

**CHIP** means Childrens Health Insurance Program.

**Chronic Disability** means a disability that: (1) is attributable to a mental or physical impairment or a combination of mental and physical impairments; (2) is likely to continue indefinitely; and (3) results in substantial functional limitations in one or more major life activities

**Claim Determination Period** is a Contract Year. However, it does not include any part of a year during which a person has no coverage under the Policy or any part of a year before the date the coordination of benefits section or a similar provision takes effect.

**Coinsurance** means the percentage of charges that the Member is responsible to pay for a covered treatment, service or supply. See section on DEDUCTIBLE, COINSURANCE, COPAYMENTS AND MAXIMUMS for additional information on Coinsurance, including the calculation of Coinsurance.

**Complaint** means any dissatisfaction expressed to Physicians Plus by a Member, or the Member's authorized representative, about Physicians Plus or Our contracted Providers.

**Complication of Pregnancy** means a condition caused by pregnancy needing medical treatment before or after termination of pregnancy. See the BENEFITS AND SERVICES- MATERNITY SERVICES section of this Certificate. Examples are: Acute nephritis; cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that can't be classified as a distinct Complication of Pregnancy but are connected with management of a difficult pregnancy. Also included are: Medically Indicated cesarean section; terminated ectopic pregnancy; spontaneous termination that occurs during a pregnancy in which a viable birth is impossible; hyperemesis gravidarum; and pre-eclampsia.

**Confinement** means the period starting with a Member's admission on an inpatient basis to a hospital or other facility for the treatment of an illness or injury and ending with the Member's discharge from the same facility. However, if the member is transferred and/or admitted to another facility for continued treatment of the same or related illness or injury, within 60 days, it will be considered one Confinement.

**Congenital Anomaly** means a defective development or formation of a part of the body that is determined by a licensed medical doctor to have been present at birth.

**Continuity of Care** means continued care provided by a PCP or specialist that is no longer a Participating Provider with Physicians Plus. See Continuity of Care discussion in the OTHER POLICY PROVISIONS section of this Certificate.

**Contract Year** means the 12 month period of time following the effective date indicated in the Group Master Policy. (i.e., June 1, 2008 - May 31, 2009 or January 1, 2009 - December 31, 2009). In some instances the Group Master Policy may specify a benefit period that is different than a Contract Year. In those situations, benefit limits will be applied based on the special benefit period rather than the Contract Year. Please consult your employer's Group Master Policy.

**Copayment/Copay** means a specified dollar amount for a covered treatment, service or supply that a Member is responsible to pay before benefits are payable under this Policy. See section on DEDUCTIBLE, COINSURANCE, COPAYMENTS AND MAXIMUMS for additional information.

**Cosmetic Treatment** means medical or surgical procedures to alter normal structures of the body, as determined by Physicians Plus, in order to improve appearance, treat a nervous or mental disorder or to improve self-esteem.

**Covered Charge** means that part of a Provider's charges for a treatment, service or supply that is covered by Physicians Plus under this Plan. The Covered Charge may be less than the Provider's Billed Charge.

**Creditable Coverage** means coverage under the following:

- (A) A group health Plan;
- (B) Health insurance or health maintenance organization coverage;
- (C) Medicare;
- (D) Medicaid;
- (E) Military health care;
- (F) A medical care program of the Federal Indian Health Service or of a American Indian tribal organization;
- (G) A state health benefits risk pool;
- (H) A health Plan offered under the Federal Employee health Benefits Program;
- (I) A public health Plan as defined under federal regulations; or
- (J) A health benefit Plan under Section 5(e) of the Peace Corps Act.

**Custodial or Maintenance Care** means care which can be learned and performed by a person who is not medically trained or care which involves the maintenance of basic bodily functions whether by natural or artificial means; care which includes care required for patient safety; and care which includes Respite Care, which is care that is requested to give temporary relief to persons who normally assist with the care of the Member.

In the case of Confinement in a Hospital or Skilled Nursing Care facility:

- Room and board; nursing care; physical medicine services; and assistance with Activities of Daily Living, which is provided to an individual for whom it cannot be reasonably expected that: the treatment will enable that person to live outside an institution; or the individual has reached the maximum level of improvement or plateau in progress, as determined by Physicians Plus.

In the case of home care services, including but not limited to:

- Nursing care; physical medicine services; and assistance with Activities of Daily Living, when the Member has achieved a maximum level of improvement or plateau in progress as determined by Physicians Plus.

Examples of Custodial or Maintenance Care include, but are not limited to the following:

- (A) Services provided in an assisted living center or residential facility or assisted living within the home;
- (B) Assistance with Activities of Daily Living and homemaking services, such as shopping, housekeeping and laundry;
- (C) Administration of medication, eye drops or ointments;
- (D) Entertainment or recreation therapy;
- (E) Treatment of minor skin problems and wounds that do not require surgical procedures or injectable antibiotics;
- (F) Treatment of chronic bed or pressure sores when it cannot be reasonably expected that the treatment will either: 1) Improve the function of the individual; or 2) Have a reasonable chance to heal the sore;
- (G) Checking vital signs when the medical condition is stable;
- (H) Checking routine or maintenance oxygen levels;
- (I) Routine or maintenance nebulized treatments;
- (J) Irrigation and other routine care of catheters;
- (K) Maintenance care of ostomies;
- (L) Routine use and care of feeding tubes;
- (M) Routine care of braces and similar devices;
- (N) Administration of routine or maintenance subcutaneous insulin;
- (O) Routine or maintenance blood sugar level; and
- (P) Maintenance bowel program.

This list is not intended to be complete. Physicians Plus will determine whether certain other services will meet the criteria for Custodial or Maintenance Care.

**Deductible** means a specific dollar amount for a covered treatment, service or supply that a Member is responsible to pay before benefits are payable under this Policy. See section on DEDUCTIBLE, COINSURANCE, COPAYMENTS AND MAXIMUM for additional information.

**Disposable Supplies** means a supply that is Medically Necessary and which has a limited life expectancy and is consumable, expendable, disposable or non-durable.

**Drug Formulary** means the list of prescription drugs that Physicians Plus has determined to be covered under the Policy when Medically Indicated and dispensed by a participating pharmacy. The Drug Formulary is developed by a committee of Physicians and pharmacists to provide the desired prescription results while controlling costs. Physicians Plus will periodically review and modify the Drug Formulary. Physicians Plus provides a copy of the current Drug Formulary to Our participating pharmacies and Physicians. The Formulary is also available on Our website.

**Durable Medical Equipment** means an item, which can withstand repeated use and which, as determined by Physicians Plus, meets any or all of the following:

- (A) Primarily used to serve a medical purpose with respect to an Illness or Injury;
- (B) Generally not useful to a person in the absence of an Illness or Injury;
- (C) Appropriate for use in the Member's home, but may not be limited to home use; and
- (D) Prescribed by a Physician.

**Eligible Dependents** include any of the following who meet the other requirements of the Policy (such as age limits and support requirements for a child of the Eligible Employee): an Eligible Employee's spouse, child, stepchild, grandchild (if the grandchild's parent is a covered dependent under 18 years of age), Legal Ward, adopted child and a child placed for adoption with the Eligible Employee.

**Eligible Employee** means an employee of the employer group, who:

- (A) appears on the Policyholder's regular payroll records (excluding temporary and/or leased employees);
- (B) is scheduled to perform the duties of his/her job with the Policyholder for at least the minimum number of hours per week as required on the policyholders current application for coverage (the required minimum shall not exceed 30 hours per week);
- (C) is Actively at Work (except where immediate coverage is required under Ins. 6.51 of the Wisconsin Administrative Code or HIPAA); and
- (D) has completed the waiting period, if any, for coverage to be effective as specified by the Policyholder's application for coverage.

**Emergency Medical Care** means Medical Services provided to a Member by a Physician or other medical professional licensed by the state in which the care is provided in connection with an Emergency Medical Condition.

Emergency medical care does not include routine health maintenance services or routine medical exams.

**Emergency Medical Condition** (as defined by State Statute 632.85) means a medical condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, 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 unborn child;
- (B) Serious impairment to the person's bodily functions; or
- (C) Serious dysfunction of one or more of the person's body organs or parts.

**Experimental/Investigative** means drugs, devices, treatment, or procedures, which in judgment of a Physicians Plus medical director, meet one of the following criteria:

- (A) Full and final approval has not been granted by the U.S. Food and Drug Administration for the treatment of the patient's medical condition;
- (B) Specific evidence shows that the drug, device, treatment, or procedure is being provided subject to: a phase I or phase II clinical trial or the Experimental arm of a phase III clinical trial; a protocol to determine the safety, toxicity, maximum tolerated dose, efficacy, or efficacy in comparison to the standard means of treatment or diagnosis; or a protocol approved by and under the supervision of an Institutional Review Board;
- (C) The published authoritative medical and scientific literature: has not defined or supports further research to define the safety, toxicity, maximum tolerated dose, efficacy or efficacy in comparison to the standard means of treatment or diagnosis; or does not demonstrate clinically significant improvement in the efficacy or outcomes for the drug, device, treatment or procedure compared to standard drugs, devices, treatments, or procedures.

**Family Coverage** means coverage that applies to a Subscriber and his/her covered dependents.

**Formulary** See definition of Drug Formulary.

**Full-Time Student** means someone who is enrolled in and attending full-time (according to the school's definition or criteria for full time) a school maintaining a regular faculty and an established curriculum and having an organized body of students in attendance. It includes colleges, universities, technical and mechanical schools and similar institutions as determined by Physicians Plus. Full-Time Student does not include a student taking only/all classes on line.

**Grievance** means any dissatisfaction with services provided by Us or our claims practices that is expressed in writing to Physicians Plus by, or on behalf of, a Member.

**Group Master Policy** means the contract that Physicians Plus issued to the employer, trustee, union, association, organization or other entity known as the Policyholder. In it, We agree to provide healthcare coverage to covered Members of a group through benefit payments to health care Providers, subject to the terms, conditions and provisions of the Policy.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**Hospital** means an institution providing 24-hour continuous service to confined patients. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons. A professional staff of licensed Physicians must provide or supervise its services. It must provide general medical and surgical facilities and services. Hospital also means a specialty Hospital approved by Physicians Plus and licensed and accepted by the appropriate state or regulatory agency to provide diagnosis and short term treatment for patients who have specified medical conditions. A Hospital does not include any institution or facility that We determine is:

- (A) A convalescent or extended care facility within or participating with the Hospital;
- (B) A clinic;
- (C) A nursing, rest or convalescent home, or extended care facility;
- (D) An institution operated mainly for care of the aged or for treatment of mental disease, chemical dependency;  
or
- (E) A health resort, spa or sanitarium.

**Illness** means a Physical Illness or a nervous or mental disorder or alcohol or other drug abuse.

**Inpatient Hospital Services** means Medically Indicated services that are provided in a Hospital or to a Member who is a bed patient in the Hospital.

**Immediate Family** means Your spouse, children, parents, grandparents, brothers and sisters and their own spouses.

**Immediate/Urgent Medical Care** means Medical Services provided to treat the onset of symptoms of an Illness or Injury that requires immediate medical attention, is not life- or limb-threatening, and could worsen if not treated promptly, as determined by Physicians Plus. Immediate/Urgent Medical Care received out of the Service Area does not include follow-up care that can be safely postponed until the Member returns to the Service Area to receive such care.

**Infertility Treatment** means services, tests, supplies, devices, or drugs, which are intended to: promote fertility; achieve pregnancy; or treat an Illness causing an infertility condition when such treatment is done solely in an attempt to bring about a pregnancy.

**Injury** means bodily damage resulting directly from an accident and independently of all other causes. A dental accident caused by chewing is not considered an accidental dental Injury. To be covered, the Injury and treatment must occur while a Member is covered under the Policy, or was continuously covered under the Policyholder's immediately preceding group health insurance Policy or self-insured group health benefits Plan, and the treatment was covered under the prior Policy or Plan.

**In-Network/On Panel** refers to treatment, services and/or supplies received from a Participating Provider.

**Inpatient Admission** means a Hospital stay for a period of greater than 24 hours. A person is not inpatient on any day on which the person is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

**Intermediate Nursing Care** means care that is a combination of a medically oriented program of uncomplicated treatment plans requiring periodic medical supervision, as determined by Us. Basic care includes physical, emotional, social and other restorative services. The nursing care requires the skills of a registered nurse in administration, including observation and recording of reactions and symptoms, and supervision of nursing care.

**Late Enrollee/Enrollment** means an Eligible Employee or dependent of an Eligible Employee, who enrolls under the Policy other than on:

- (A) The earliest date on which coverage can become effective under the terms of the Policy; or
- (B) A special enrollment date.

If You do not apply within 31 days of a qualifying event and do not qualify for a special enrollment, You and any affected dependents will serve a 12-month waiting period that will begin on the date that you apply for coverage and Your coverage will be effective on the first of the month immediately following the 12-months waiting period.

**Legal Ward** means an unmarried individual who is under 18 years of age and for whom the covered employee has been appointed guardian by court order.

**Licensed Skilled Nursing Facility** means 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; and restorative and activity programs. These must be provided under professional direction and medical supervision as needed.

**Lifetime Maximum Benefit** means the maximum amount that we will pay (medical and prescription (if applicable)) for benefits during the entire period of time that you are covered under this Policy, including any renewals, and all other policies that are consecutively issued by Physicians Plus to the Policyholder prior to and after this Policy. When a Lifetime Maximum Benefit applies, it is described in your Schedule of Benefits.

**Long Term Care/Therapy** means any care/therapy that extends beyond 3 months.

**Maintenance Care/Therapy** means ongoing care/therapy delivered after the Acute phase of an Injury or Illness has passed. It begins when a Member's recovery has reached a plateau, or improvement in the Member's condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. Physicians Plus and/or the Provider of care will make the determination of what constitutes Maintenance Care/Therapy after reviewing a Member's case history or treatment plan submitted by a Provider.

**Maintenance Drugs** are medications frequently used to treat chronic conditions. They are often available in generic form.

**Maternity Care/Services** means Professional Services for prenatal and postnatal care. This includes: laboratory procedures; delivery of the newborn; Medically Indicated cesarean section and porro-cesarean sections; and care for mis-carriages.

**Maximum Dependent Age** means 26 years old.

**Medically Indicated or Medically Necessary** means a service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, Physician or other health care Provider that is required to identify or treat a Member's Illness or Injury and which is, as determined by Physicians Plus:

- (A) Consistent with the symptom(s) or diagnosis and treatment of the Member's Illness or Injury;
- (B) Appropriate under the standards of acceptable medical practice to treat that Illness or Injury;
- (C) Not solely for the convenience of a Member, Physician, Hospital or other health care Provider;
- (D) The most appropriate service, treatment, procedure, equipment, drug, device or supply that can be safely provided to the Member in the most cost effective manner; and
- (E) Not deemed Experimental or Investigational in nature.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for a particular Injury or Illness does not necessarily mean it is Medically Indicated.

**Medical Services** means Professional Services performed by a Physician or other health care Provider in the treatment of Illness or Injury.

**Medical Supplies** means items, which are:

- (A) Primarily used 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 items that can be safely provided to a Member in the most cost effective manner;
- (D) Prescribed by a Physician; and
- (E) Not primarily for comfort or convenience.

**Medicare** means benefits available under Title XVIII of the Social Security Act of 1965, and as further amended.

**Member** means the Subscriber or one of his/her Eligible Dependents that has been enrolled and approved for coverage by Physicians Plus and for whom We have accepted the appropriate premium.

**Meriter Choice Reward Plan facility** means a hospital or ambulatory surgery center identified as a Meriter Choice Reward Plan provider in the Physicians Plus Provider Directory.

**Miscellaneous Hospital Expense** means the regular Hospital charges (but not room and board, nursing services and ambulance services) We cover under the Policy for care of an Illness or Injury requiring either inpatient hospitalization or outpatient treatment at a Hospital. For outpatient care, this includes emergency room charges.

**Non-Participating Provider** refers to a Physician, Hospital or other healthcare facility or Provider that is NOT listed in the most current Physicians Plus Provider Directory.

**Off-Panel/Out of Network** refers to treatment, services and/or supplies received from a non-Participating Provider.

**On-Panel/In Network** refers to treatment, services and/or supplies received from a Participating Provider.

**Orthotic** means a device only used to re-establish or facilitate alignment for the performance or function of a particular body part. The device may be made biomechanically or custom molded to each individual's body part to allow its proper anatomical function.

**Outpatient Behavioral Health or AODA Services** means Medically Indicated nonresidential services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems provided to a Member and, if for the purpose of enhancing the treatment of the Member, to a collateral, by any of the following Participating Providers:

- (A) A program in an outpatient treatment facility, if both the program and facility are approved by DHFS and established and maintained according to rules promulgated under s. 51.42 (7) (b), Wisconsin Statutes;
- (B) A licensed Physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office;
- (C) A licensed psychologist who is listed in the National Register of Health Service Providers in psychology;
- (D) A psychologist who is certified by the American Board of Professional Psychology; or
- (E) A state certified masters level clinician such as a clinical social worker or marriage and family therapist.

**Out of Network** refers to treatment, services and/or supplies received from a non-Participating Provider.

**Outpatient Treatment Facility** means a facility licensed or approved by the Department of Health and Family Services (DHFS). Its outpatient services must meet DHFS standards. The facility must provide the following outpatient services to prevent or treat an Illness:

- (A) Comprehensive diagnostic and evaluation services;
- (B) Outpatient care and treatment, pre-care, aftercare, emergency care, rehabilitation and habilitation, and supportive transitional services; and
- (C) Professional consultation.

**Participating** means listed in the most current Physicians Plus Provider Directory.

**Participating Hospital** means a hospital that is listed in the most current Physicians Plus Provider Directory.

**Participating Provider or Facility** means a physician, other healthcare provider or facility listed in the most current Physicians Plus Provider Directory.

**Physical Illness** means a bodily disorder, disease, pregnancy or Complication of Pregnancy. This does not include a nervous or mental disorder or alcohol or other drug abuse.

**Physician** means a licensed doctor of medicine or doctor of osteopathy. When We are required by law to cover the services of any other licensed medical professional under the Policy, a Physician also includes such other licensed medical professional (for example, a podiatrist, dentist or chiropractor) who:

- (A) Is acting within the lawful scope of such professional's license; and
- (B) Performs a service that would be payable under the Policy.

**Physicians Plus or PHYSICIANS PLUS** means Physicians Plus Insurance Corporation.

**Physicians Plus Insurance Corporation** means a stock insurance corporation with its principal office in Madison, Wisconsin, organized and existing under Chapter 611, Wisconsin Statutes.

**Placement/Placed for Adoption** is defined in section 632.896 (1)(c) of the Wisconsin Statutes and involves the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with the person terminates upon the termination of such legal obligation.

**Plan** means the health care coverage provided by the Policy.

**Policy** means the agreement between Physicians Plus and the Policyholder for Physicians Plus to provide insurance coverage to the group's Eligible Employees (or, in the case of a non-group Policy, the Policyholder) and their Eligible Dependents. The Policy consists of this Medical Certificate, the Schedule of Benefits, any amendments and/or addendums, any riders, the Policyholder's application and any supplemental applications, the individual applications of the Members, and (for group policies) the Group Master Policy.

**Policyholder** means the employer, trustee, union, association, organization or other entity with whom We have entered into the Group Master Policy or, for non-group coverage, the Subscriber.

**Prior Authorization or Prior Authorized** means a prior written or verbal approval from Physicians Plus to a Member that a specific medical and/or drug treatment or service or supply will be covered under the Policy, subject to all other Policy limits and provisions.

**Pre-Existing Condition** means an a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the date that the Member is enrolled for coverage under the Policy.

**Primary Care Physician (PCP)** means a Participating Provider that You choose to provide Your primary health services. You must choose Your PCP from the list of PCP's We make available to You. PCP's include family practitioners, internists, pediatricians; and obstetrics/gynecologists.

**Professional Services** means services provided by a Physician or other healthcare professional to treat the Member's Illness or Injury.

**Prosthetic Device/Prostheses** means an artificial device to replace all or part of an external body part.

**Provider** means a Physician, Hospital, skilled nursing facility or other health care practitioner or supplier properly licensed, certified or otherwise authorized pursuant to the law of jurisdiction in which care or treatment is received.

**Reconstructive Surgery** means surgery that is incidental to an Injury, sickness, or Congenital Anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body or when required by the Women's Health and Cancer Rights Act (WHCRA) of 1998 (see BENEFITS AND SERVICES-SURGICAL SERVICES). Cosmetic surgery is not Reconstructive Surgery.

**Recurrent Miscarriage** means two or more consecutive pregnancy losses prior to a gestational age of 20 weeks.

**Respite Care or Rest Care** meant patient care provided in the home or institution intermittently in order to provide temporary relief to the family home care giver.

**Schedule of Benefits** means the document of that name given to you by Us that lists the amount of copayments, coinsurance and deductibles that You are required to pay under the Policy, as well as other coverage details such as benefit maximums.

**Service Area** means specific ZIP codes in those counties in Wisconsin, in which the Participating Providers are approved by Us to provide Professional Services to Members. Our Service Area is illustrated in the Provider listing We distribute to Subscribers.

**Significant Break in Coverage** means a period of more than 63 consecutive days during which a person does not have any Creditable Coverage. A waiting period is not counted in determining a Significant Break in Coverage.

**Single Coverage** means coverage that applies only to the Subscriber.

**Skilled Care** means care requiring the skills of a licensed physical, occupational or speech therapist that is approved by Physicians Plus, ordered by the Attending Physician and is Medically Indicated, as determined by Physicians Plus.

**Skilled Nursing Care** means care that is furnished on an order by the Attending Physician and is Medically Indicated, as determined by Us. Skilled Nursing Care consists of complex services that can only be safely and effectively provided by professional personnel such as a licensed registered or practical nurse and is provided either directly by or under the supervision of these personnel. Services to support Activities of Daily Living provided by a licensed registered or practical nurse are not considered Skilled Nursing Care.

**Sound Natural Tooth** means a tooth that would not have required restoration in the absence of a Member's traumatic Injury, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with a crown or root canal therapy.

**Specialty Providers** mean a Provider other than a PCP.

**Specific Evidence** means:

- (A) The Member's medical records;
- (B) The protocols pursuant to which treatment, device, procedure or drug is being delivered;
- (C) Any consent documents the Member must complete prior to undergoing the procedure or treatment or being administered the drug or device;
- (D) The published authoritative medical or scientific literature regarding the treatment, drug, device, or procedure available at the time of request;
- (E) Regulations, manual issuance, publications and other official actions of the U.S. Food and Drug Administration of the U.S. Department of Health and Family Services.

**Subscriber** means the employee eligible for coverage under the Policy (or in the case of non-group coverage, the Policyholder) who has properly subscribed for coverage and is approved by Physicians Plus for coverage under the Policy, and for whom We have accepted the appropriate premium.

**Surgical Services** means operative procedures, including preoperative and postoperative care, performed by a Physician and recognized by Us as Medically Indicated for the treatment of an Illness or Injury.

**Totally Disabled/Total Disability** means the Member's inability, due to Illness or Injury, to perform the essential functions or duties of his/her job for the Policyholder or of any job for pay or profit, as determined by Physicians Plus. If a Member does not have a regular occupation, Totally Disabled or Total Disability means the Member's inability, due to Illness or Injury, to substantially engage in normal activities of a person of the same age and sex, as determined by Physicians Plus. The Member must be under the regular care of a Physician for the disability. Physicians Plus has the right to examine such Member as is reasonably necessary to confirm the Total Disability.

**Transitional Treatment Services** means Medically Indicated services for the treatment of nervous or mental disorder or alcoholism or other drug abuse problems that are provided under one of the following categories:

- (A) Behavioral health services for adults in a day treatment program offered by a Provider certified by the Department of Health and Family Services (DFS) under Wisconsin Regulation s. HFS 61.75.
- (B) Behavioral health services for children and adolescents in a day treatment program offered by a Provider certified by DFS under Wisconsin regulation s. HFS 40.04.
- (C) Services for persons with chronic mental Illness provided through a community support program certified by DFS under Wisconsin regulation s. HFS 63.03.
- (D) Residential treatment programs for alcohol or drug dependent persons or both certified by DFS under Wisconsin regulation s. HFS 75.14 (1) and (2).
- (E) Services for alcoholism and other drug problems provided in a day treatment program certified by DFS under Wisconsin regulation s. HFS 75.12 (1) and (2).
- (F) 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.

**Usual and Customary** means the Usual and Customary amount payable based upon the average charge for the same service provided by other Providers of a similar type, training, and experience, in the same or similar geographical area and should not exceed the fees that the Provider would charge any other payor for the same services. Other factors such as, but not limited to, complexity, degree of skill or type of Provider may also determine a Usual and Customary fee. Amounts above the Usual and Customary amounts are not paid by this Policy and are not applied to Policy and/or benefit maximums and/or Deductible amounts, Copayments and Coinsurance.

**We, Us, Our** means Physicians Plus Insurance Corporation or Physicians Plus.

**You, Your** means the Member and/or Subscriber.



Printed on recycled paper

©2009 Physicians Plus Insurance Corporation

P+3872-1001