Physicians Plus Insurance Corporation
2650 Novation Parkway, Suite 400
Madison, WI 53713

www.pplusic.com
email: ppicinfo@pplusic.com

Point of Service (POS) 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 Summary of Benefits.

This is our standard Point of Service (POS) Policy. This policy allows you to seek services with participating and nonparticipating providers. The level of benefits is determined by the participation status of the provider. If you see a non- participating provider benefits will be less then if you had services performed by a participating provider.

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).

Your Policy covers services received from a Non-Participating Provider and 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.

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IMPORTANT INFORMATION

If You have any questions about your Policy, Providers or Benefits please contact Our Member Service department at (608) 282-8900 or (800) 545-5015 *BEFORE* you obtain services.

IMPORTANT NOTICE: You are strongly encouraged to contact Physicians Plus before scheduling appointments or elective procedures so we can verify the participating or non-participating status of the providers involved in your care. This includes, for example, anesthesiologists, radiologists, pathologists, facilities, clinics and laboratories.

This information may help you select providers and will likely affect the level of copayment, deductible and amount of coinsurance applicable to the care you receive. The information contained in this directory may change during your plan year. Please visit Physicians Plus at www.pplusic.com or call Member Service at (608) 282-8900 or (800) 545-5015 to learn more about the participating providers in your network and the implications, including financial, of receiving care from non-participating providers.

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

GRANDFATHERED PLAN INFORMATION

Under the Patient Protection and Affordable Care Act (PPACA or Affordable Care Act), a grandfathered health plan may be able to retain certain basic health coverage that was already in effect when the law was enacted on March 23, 2010.

Being a grandfathered health plan means that your plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. Please refer to your Summary of Benefits for all cost sharing details.

Grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer.

For ERISA plans: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For individual market policies and nonfederal governmental plans you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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WELCOME TO PHYSICIANS PLUS INSURANCE CORPORATION

It is Your responsibility to know Your benefits. Please carefully read the information provided in this Medical Certificate, Your Summary 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.

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.

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

1. This is an POS Policy - YOU have the CHOICE to seek services with a particiapting provider or a non-participating provider. If you seek services with a non -participating provider your benefits will be less than if you seek services with a participating provider. All benefis are determined at the time of claim.

   Some Providers may practice at more than one clinic or facility. Please refer to the index of the Provider Directory for a listing of Participating Providers and locations. Providers are only considered Participating Providers when services are provided at the locations listed in the Provider Directory. Our Provider Directory is available on our website at 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 approved by Physicians Plus may be required. **Please talk with Your PCP to obtain Prior Authorization from Physicians Plus before services are provided.**

4. Prior Authorization is also required for: (1) inpatient care including hospitalizations, hospital rehabilitation, hospice care and skilled nursing facilities (2) the location at which certain services must be received, and (3) the Participating Provider from whom certain services must be received. For a complete list of Prior Authorization requirements, please visit www.pplusic.com and click on Member then Member Materials or contact Our Member Service department at (608) 282-8900 or 1-800-545-5015.

5. If You do not obtain Prior Authorization when required, services may not be covered. Please contact Our Member Service department if You have questions regarding Our Prior Authorization requirements.

6. **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. The change will be effective on the first of the month following Our notification of the change.

7. **PLEASE IMMEDIATELY READ THE EMERGENCY AND IMMEDIATE/URGENT MEDICAL CARE SECTION OF THIS CERTIFICATE.**

8. **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.

MEMBER RIGHTS AND RESPONSIBILITIES

We believe that you have certain basic rights regarding your health care. In addition, we believe that you also have some basic responsibilities. Your rights and responsibilities are described below.

You have the right to:

1. Receive quality health care services that are right for You.
2. Receive information about Physicians Plus, its services, its practitioners and providers, and members' rights and responsibilities.
3. Be treated with respect and recognition of your dignity and right to privacy. You also have a right to the privacy of your medical and financial records, unless you allow their release.
4. Participate with practitioners and providers in decision-making regarding your health care.
5. A candid discussion of appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
6. Information about preventive health services including self-care and how to stay healthy.
7. Voice complaints or appeals about Physicians Plus or the care provided to you.
8. Make recommendations regarding Physicians Plus' member rights and responsibilities policy.

You have the responsibility to:

1. Read available member materials about your health plan, benefits and coverage.
2. Build a relationship with your primary care provider and keep your appointments or give proper notice if you must cancel.
3. Provide, to the extent possible, information that Physicians Plus and its practitioners and providers need in order to care for you.
4. Provide correct health insurance information and arrange to pay for services if you are billed.
5. Ask questions about your illness, your treatment plan, and how to manage your health.
6. Follow the plans and instructions for care that you agreed on with your practitioners.
7. Treat health care providers, employees and other patients with respect and display behavior proper for a health care setting.
8. Understand your health problems and participate to the extent possible in developing mutually agreed-upon treatment goals.

IMPORTANT PHONE NUMBERS AND ADDRESSES

Physicians Plus Insurance Corporation

WEBSITE: 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.
Visit our website at *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
Fax: (608) 327-0321
E-Mail: ppicinfo@pplusic.com

Please note: Hearing- and Speech-disabled members can receive assistance from Wisconsin Relay (part of the Telecommunications Relay System) by dialing 711 anywhere in the United States.

Behavioral Health and/or Alcohol or Drug Abuse
For Prior Authorization please contact Behavioral Health Consultation System at:
Phone: (608) 233-3575 or (800) 683-2300

Pharmacy Services
Phone: (608) 260-7803 or (800) 545-5015
Fax: (608) 327-0324

Claims: PHYSICIANS PLUS Mailing Addresses

Medical Claims:

Physicians Plus Insurance Corporation
P.O. Box 269017
Plano, TX 75026

Chiropractic Claims:

ChiroTech America, Inc.
N14 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
2650 Novation Parkway
Madison, WI 53713

1. GENERAL GUIDELINES

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

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 as long as you are eligible that are identified as "Physicians Plus will cover". 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. 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 Summary 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: Physicians Plus requires all members to 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.

You have the right to designate any PCP who participates in our network and who is available to accept you and/or your family members. For children, you may designate a pediatrician as the PCP; women may select an OB/GYN provider.

For information on how to select a PCP, and for a list of the Participating PCP's, visit our website at www.pplusic.com or contact our Member Service department at (608) 282-8900 or (800) 545-5015.

You do not need Prior Authorization from your Primary Care Physician or Physicians Plus to obtain obstetrical or gynecological care from a health care professional that is a Physicians Plus Participating Provider who specializes in obstetrics or gynecology. The Participating Provider, however, may be required to comply with certain procedures,

including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Participating health care professionals who specialize in obstetrics or gynecology refer to the Physicians Plus Provider Directory or contact our Member Service department at (608) 282-8900 or (800) 545-5015.

PRE-EXISTING CONDITION LIMITATION: **PRE-EXISTING CONDITION LIMITATION:** Pre-existing condition limitations do not apply to children 0-18. Pre-existing for adults DOES apply to POS plans when services are provided by non-participating providers.

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins.

This exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have.

PRE-EXISTING BENEFIT LIMITS: This Pre-Existing Condition exclusion applies to services received from non-Participating Providers only.

Treatment, services and supplies that are received from any non-Participating Provider and that relate to a Pre-Existing Condition are excluded for the first 6 months after the member's enrollment date. The Pre Existing Condition exclusion does not apply to late enrollees (late enrollees do not have coverage).

The Pre-Existing Condition exclusion DOES NOT apply to:

1) Members ages 0-18;
2) Any person who, on his/her enrollment date, had at least 6 consecutive months of Creditable Coverage without a break of 63 or more consecutive days (a "Significant Break in Coverage");
3) Pregnancy related expenses;
4) A dependent child who, within 30 days of his/her date of birth, had any Creditable COVERAGE and has not had any Significant Break in Coverage before enrolling under this policy;
5) A dependent child who is adopted or placed for adoption before the age of 18 and who, within 30-days of adoption or placement for adoption, had any Creditable Coverage and has not had any Significant Break in Coverage before enrolling under this policy; or
6) Genetic information, in the absence of a diagnosis of an illness related to such information.

If a member has less than 6 consecutive months of Creditable Coverage on his/her enrollment date, Physicians Plus will credit the member for the period of consecutive Creditable Coverage that the member had immediately prior to enrollment without a Significant Break in Coverage.

If a member has a Significant Break in Coverage, any days of Creditable Coverage that occur before the Significant Break in Coverage will not be counted by Physicians Plus to reduce the Pre-Existing Condition exclusion time period. Waiting periods will not count as a Significant Break in Coverage.

For administrative efficiency and economy, Physicians Plus may elect to not apply the Pre-Existing Condition exclusion to lower dollar claims. Payment and coverage of such claims does not constitute a waiver by Physicians Plus of the Pre-Existing Condition exclusion.

Prior Authorization: Some services obtained from a Provider other than Your PCP require written approval by Physicians Plus before services are provided. This term is frequently referred to as Prior Authorization. Not all services offered by a Participating Provider may be covered under your Policy with Physicians Plus. Prior Authorization is required for the location at which some services are received. For a complete list of Prior Authorization requirements, please visit www.pplusic.com and click on Member then Member Materials or contact our Member Service department at (608) 282-8900 or (800) 545-5015.

Your Particiapting Provider will fill out the information needed on the Physicians Plus 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 request. If a Prior Authorization is required but not obtained, Physicians Plus will not pay for the treatment(s), services or supplies provided or a penalty may apply. (See the BENEFIT REDUCTION TABLE (next page) AND the GENERAL POLICY EXCLUSIONS AND LIMITATIONS section of this Certificate). All services and benefits are determined at the time of claim; not all services authorized are covered benefits.

The following services are examples of services that DO NOT require Prior Authorization when a Participating Provider provides the services, when medically necessary and a covered benefit:

- Autism, Non-Intensive therapy services;
- Chiropractic care (Long-Term Care/Therapy and/or Maintenance Care/Therapy is not covered);
- Dental care (if Your Policy includes dental care): You must obtain dental services from a Participating dentist.
- Emergency Medical Care when the Member is outside of the Physicians Plus Service Area. You must contact Physicians Plus within 48 hours of care;
- Immediate/Urgent Medical Care with a Participating Provider;
- Obstetric and gynecological services performed by a Participating OB/GYN or a Participating licensed nurse practitioner within the scope of the nurse's license;
- Office visits provided by your PCP;
- Routine eye exams and refractions (one exam and refraction per Member per Calendar Year);
- Routine hearing exams (one exam per Member per Calendar Year).

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. For a complete list of Prior Authorization requirements, please visit www.pplusic.com and click on Member then Member Materials or contact our Member Service department at (608) 282-8900 or (800) 545-5015.

- Acupuncture;
- Admissions – Hospital or Facility: Medical & Behavioral Inpatient, Inpatient Hospice, Inpatient Rehabilitation, Skilled Nursing Facilities or other Inpatient Care;
- Autism, Intensive Therapy services. To obtain Prior Authorization and/or find a Participating Provider, contact UW Behavioral Health at (608) 233-3575 or (800) 683-2300.
- BH/AODA: Behavioral Health (BH) (nervous or mental illness) and Alcohol or Drug Abuse (AODA) (chemical dependency) services. To obtain Prior Authorization and/or help finding a Participating Provider, contact UW Behavioral Health at (608) 233-3575 or (800) 683-2300.
- Dental care that requires treatment, services or supplies at an outpatient Hospital or Ambulatory Surgery Center;
- Genetic testing;
- Hitech radiology (this includes Nuclear Medicine, CT/CAT, MRI, MRA's)
- Home care services, supplies and therapies, including, but not limited to, Skilled Nursing Care;
- Hospice care;
- Outpatient/Ambulatory surgeries/services/procedures that may be considered cosmetic (including, but not limited to, reduction mammoplasties, gynecomastia, blepharoplasties, Botox injections and septorhinoplasties);
- Prosthesis, Limb (All);
- Rental or Purchase of Durable Medical Equipment and Supplies: Including diabetes supplies, Durable Medical Equipment and Supplies (see Summary of Benefits (SOB) for dollar amounts);
- Specialty Care;
- Transplants (All).

BENEFIT REDUCTION and PRIOR AUTHORIZATION: It is the Member's responsibility to obtain Prior Authorization when required. The services listed below require Prior Authorization, as indicated below.

Benefit Reduction Calculation. If a service is NOT Prior Authorized when Prior Authorization is required below, We will reduce the allowed amount by 50%. It is the Member's responsibility to pay: (1) his/her deductible and coinsurance amounts, and (2) the balance due or the amount by which our benefit was reduced.

In the case of any service indicated to have no coverage, the Member must pay the full amount of the Provider's charges. A benefit reduction will be applied as a non-covered service. Benefit reductions are not applied to out-of-pocket or benefit maximum(s).

SERVICE(S)	PARTICIPATING PROVIDER	NON - PARTICIPATING PROVIDER
Inpatient Hospital: Admissions, Care and Services	Requires Prior Authorization. No coverage if Prior Authorization is not obtained.	Requires Prior Authorization. 50% benefit reduction applies when Prior Authorization is not obtained.
Hospice Care: Inpatient Admissions and/or Outpatient Care and Services	Requires Prior Authorization. No coverage if Prior Authorization is not obtained.	Requires Prior Authorization. 50% benefit reduction applies when Prior Authorization is not obtained.
Skilled Nursing: Confinement (Nursing Home) care and Sevices including Therapies	Requires Prior Authorization. No coverage if Prior Authorization is not obtained.	Requires Prior Authorization. 50% benefit reduction applies when Prior Authorization is not obtained.
Home Health: Care and Services including Therapies	Requires Prior Authorization. No coverage if Prior Authorization is not obtained.	Requires Prior Authorization. 50% benefit reduction applies when Prior Authorization is not obtained.
Durable Medical Equipment and Supplies: ALL CPAPs, all Purchases or Rentals over the amount indicated on your Summary of Beneifts	Requires Prior Authorization. No coverage if Prior Authorization is not obtained.	
Limb Prosthetics	Requires Prior Authorization. No coverage if Prior Authorization is not obtained.	
Cochlear Implants	Requires Prior Authorization. No coverage if Prior Authorization is not obtained.	
Behavioral Health and/or Alcohol or Drug Abuse Services.	Prior Authorization is requied to determine Medical Necessity for services with Partipating and Non Participating Providers. Contact Behavioral Health Case Management at (608) 282-8940 or (800) 683-2300.	
All Transplants	Requires Prior Authorization. No coverage if Prior Authorization is not obtained.	

PROVIDER DIRECTORY: The printed 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 but is subject to change without notice. To obtain additional information or a new Provider Directory please contact our Member Service department. You also can find the most current updated list of Physicians Plus Participating Providers on Our website at *www.pplusic.com*

Some Providers may practice at more than one clinic. Please refer to the index of the Provider Directory to see all Participation locations. 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 denied services due to the lack of documentation/documentaion, billing errors, costs, billing and/or inaccurate coding practices (as determined by national standard coding guidelines) and/or the quality of treatments, services and supplies provided by an out-of-network provider.

RENEWAL and TERMINATION: The Policyholder may have the Policy renewed, on the terms We apply to similar risks, for an additional period of time equivalent to the expiring term unless, at least 60 days prior to the expiration date in the policy, We provide written notice to the Policyholder that we intend to terminate the policy, or if the terminiation is due to failure to pay premium, a notice is given not less than 10 days prior to the termination that includes the consequesnces of the failure to pay premium.

If the renewal notice We provide the Policyholder is on less favorable terms, or contains a premium increase of more than 25 percent and is not due to a significant change in risk for the Policyholder, the changes cannot go into effect until 60 days have passed since We provided notice of the changes. If the renewal notice is not delivered more than 60 days prior to the renewal date, no changes can go into effect until at least 60 days after the renewal notice is delivered. The Policyholder will be offered the opportunity to cancel the policy at any time during this 60-day period. If the Policyholde relects to cancel the renewal policy during this 60-day period, return premiums or additional premium charges will be calculated proportionately on the basis of the old premium. If We do not notify the Policyholder of the new premium or terms prior to the renewal date, We will continue the policy for an additional period of time equivalent to the expiring term and at the same premium and terms as the expiring policy.

2. DEDUCTIBLE, COINSURANCE, COPAYMENTS AND MAXIMUMS

Deductibles, Coinsurance, Copayments and/or Maximums are calculated on a Calendar Year basis and will be applied to services as shown in Your Summary of Benefits. When the applicable Deductible, Copayment, Coinsurance and/or Out-of-Pocket Maximums (if any) shown in the Summary of Benefits is met, benefits for services are payable at the applicable level also shown in the Summary 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 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 and any riders or amendments that may apply.

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 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 Summary 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 Calendar 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 Summary 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 Calendar Year. The Summary of Benefits also shows which out-of-pocket expenses (Deductibles, Coinsurance and for some policies, Copayments) that accumulate toward the out-of-pocket limit. Amounts in excess of Covered Charges (other than Deductibles, Coinsurance and for some policies, Copayments) do not accumulate toward the out-of-pocket limit. After the applicable Calendar 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 Calendar 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 Summary of Benefits.

BENEFIT MAXIMUMS

The Policy's Summary of Benefits may establish an annual maximum benefit for Essential Health Benefits. That annual maximum benefit would take into account only Essential Health Benefits that you receive.

The Policy's Summary of Benefits also may establish a separate maximum benefit (annual and/or lifetime) that only applies to Non-Essential Health Benefits. Either maximum limits the benefits that You may receive under this Policy.

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.

"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, urgent care, routine health care, dental care, maintenance treatment, services and/or supplies and/or routine medical exams.

Meriter Hospital is the Physicians Plus Participating Hospital in the Madison Area. UW Hospital, St. Mary's Hospital in Madison, Janesville and the St. Mary's Emergency facility in Sun Prairie as well as Mercy Hospital in Janesville are not Participating facilities for Physicians Plus. Please see your Provider Directory for a complete list of Participating facilities in your home and work 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 Emergency Medical Care 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 (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 are responsible to 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. This may result in additional out-of-pocket expenses.

All Physicians Plus policies include an Emergency Room Copayment and/or Deductible and/or Coinsurance. Please read Your Summary 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.

The emergency room (ER) copayment will not apply ONLY when the patient is admitted to the Hospital (not observation) within 24 hours for the same Illness or Injury treated in the ER. 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 inpatient stay. Observation is normally billed by the Hospital as an ER visit. If so, the Copayment will apply.

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 and 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.

You are responsible for obtaining all required Prior Authorizations. For a complete list of Prior Authorization requirements, please visit www.pplusic.com and click on Member then Member Materials or contact our Member Service department at (608) 282-8900 or (800) 545-5015.

4. BENEFITS AND SERVICES

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

This is a POS Plan - The Provider of care will determine the level of Benefits for the treatment, services and supply provided.

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 *ppicinfo@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 Summary of Benefits); and
- All services must be performed by a Participating Provider at a location for the provider that is listed in the Provider Directory for ON PANEL coverage; 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 or will apply a penalty. You are responsible for obtaining all required Prior Authorizations. For a complete list of Prior Authorization requirements, please visit www.pplusic.com and click on Member then Member Materials or contact our Member Service department at (608) 282-8900 or (800) 545-5015.

ACUPUNCTURE

Physicians Plus will cover up to 12 acupuncture visits per member per Calendar Year for specific diagnoses determined by Physicians Plus. All services require Prior Authorization by Physicians Plus.

Physicians Plus will not cover acupuncture services that are not Prior Authorized; and services with Non-Participating Providers.

ANCILLARY SERVICES

Physicians Plus will cover ancillary services in conjunction with an office visit or surgical procedure up to the limits of your policy, most ancillary services are covered in full. However, cost sharing will apply when the cost sharing on your plan consists of deductible and coinsurance. Ancillary services may include but are not limited to:

- ECG (electrocardiogram)
- EEG (electroencephalogram)
- EMG (electromyography)
- X-rays
- Ultrasounds
- Allergy testing
- Allergy injections
- Dermatology procedures not cosmetic in nature
  - o Skin lesion destruction
  - o Wart destruction
- IV infusion

- Nerve conduction testing
- Nebulizer treatment
- Spirometry (breathing tests)
- Somatosensory evoked potential studies
- Cognitive testing
- In provider office surgery

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.

Physicians Plus will not cover non-emergency ground and/or 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

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 below for details.

Autism Spectrum Disorder means:

1. Autism;
2. Asperger's syndrome; or
3. Pervasive developmental 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. All Intensive level services require Prior Authorization.

Non-Intensive 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;
    a. Prior Authorization can be obtained by calling the Behavioral Health Consultation System at (608) 233-3575 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. The policy will provide intensive-level behavioral therapy (see definition above) per member per year for up to $51,700 (small employers 2-50 total employees). Therapy must be based on a treatment plan for at least 30-35 hours per week for up to a total of 4 years (48 months) (this limit includes services provided prior to coverage under this policy).

5. The policy will also provide up to $25,850 (small employers 2-50 total employees) (the dollar amount will be adjusted annually by the Department of Labor's Consumer Price Index beginning in 2011. The amounts will be adjusted accordingly) 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 by Physicians Plus. Prior Authorization can be obtained for intensive therapy services by calling the Behavioral Health Consultation System at (608) 233-3575 or (800) 683-2300.

Coverage Limitations: for small employers (employers with 2-50 total employees) coverage is limited to $51, 700 for intensive level services per insured per year if services begin between the ages of 2-9 with at least 30-35 hours of care per week for up to 4 cumulative years (48 cumulative months); and $25,850 for small employers (employers with 2-50 total employees) for non-intensive services per member per Calendar Year.

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

All services require Prior Authorization to determine Medical Necessity. Obtaining Prior Authorization is the member's responsibility and is not a guarantee of benefits. Physicians Plus will determine Your benefits based on Your available coverage at the time services were provided. Prior Authorization can be obtained for all types of service by calling the Behavioral Health Consultation System at (608) 233-3575 or (800) 683-2300.

Physicians Plus will cover the following Behavioral Health and AODA Services, subject to the 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 Facility 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 treat ment 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 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: Services for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems that are Medically Indicated at the respective level of care (e.g. residential versus day treatment) and are:

    (A) Behavioral Health services for adults provided in a day treatment program that is offered by a 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 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 Provider and that is certified by DHS under Wisconsin regulation s. HFS 75.14 (1) and (2); when residential care is Medically Indicated;
    (E) Services for alcoholism and other drug problems provided in a day treatment program of a 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 Provider in accordance with the patient placement criteria of the American Society of Addiction Medicine.

COVERAGE LIMITATIONS:

- 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.

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 (diagnosis V69.3 and 312.31); 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.

Physicians Plus will not cover immunizations not Medically Indicated, as determined by Physicians Plus.

CHIROPRACTIC SERVICES

Physicians Plus will cover Medically Indicated chiropractic services with a Provider practicing within the scope of his/her chiropractic license.

Physicians Plus will not cover: services provided 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 and oral surgery 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. Coverage does not include coverage for orthodontia services.

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. This does not include coverage for orthodontia services.

-HOSPITAL AND AMBULATORY SURGERY CENTER CHARGES: Physicians Plus will cover facility and ambulatory surgery center charges and anesthesia for dental care provided in a Hospital/Facility and/or Ambulatory Surgery Center <u>if the Member</u>: 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 by Physicians Plus.

-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 $1,250 per Member per Calendar Year.

A 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 the amount indicated in your Summary of Benefits.

-ORAL SURGERY: Physicians Plus will cover only the services listed below. An 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 an 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;
- Orthognathic Surgery and Services when medically necessary criteria established by Physicians Plus is met.

Physicians Plus will not cover (including services for an accidental injury): treatment, services and supplies not listed above or not otherwise specifically covered in this Policy; dental services performed in an urgent care or 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; orthodontia services; surgery/services to correct malocclusion (including when related to an accidential dental injury or 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.

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; services requested by a third party, including but not limited to court orders; Physicians Plus will not cover 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 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 applicable maximums.

Prior Authorization is required for certain diagnostic services (Hitech radiology this includes Nuclear Medicine, CT/CAT, MRI's and MRA's) or the locations at which at which or the Participating Provider from whom the diagnostic services must be obtained. For a complete list of Prior Authorization requirements, please visit *www.pplusic.com* and click on Member then Member Materials or contact Our Member Service department at (608) 282-8900 or (800) 545-5015.

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.en 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 applicable maximums.

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 applicable 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,

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 Summary of Benefits.

All inpatient care must be Prior Authorized by Physicians Plus before services are obtained.

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 illnesss 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 of discharge, it will be considered one or the same Confinement.

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

Physicians Plus will not cover:

(A) Any care not Medically Indicated, as determined by Physicians Plus (this includes but is not limited to maintenance and/or custodial care and services);
(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 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 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 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, liposuction and 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;
(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.

Physicians Plus will not cover: any care that is not Medically Indicated; private room and board when it is not Medically Indicated; Services, supplies and costs (including re-admission) related to services obtained and/or repeated when a member discharges themselves and/or leaves a facility/clinic against medical advice as determined by the Physician and Physicians Plus; 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.

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

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; services, supplies and costs (including re-admission) related to services obtained and/or repeated when a member discharges themselves and/or leaves a facility/clinic against medical advice as determined by the Physician and Physicians Plus; 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. Procedures and supplies related to sex transformations; reversal of sterilization and related procedures; 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. This policy covers a minimum of 30 days of coverage as outlined in Your Summary 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 from discharge, it will be considered one or the same 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; services when a member discharges themselves against medical advice; any charges related to care that is not approved by Physicians Plus.

-HOME CARE SERVICES: All home care services require Prior Authorization. Physicians Plus will cover not less than 40 home care visits prior authorized by Physicians Plus as Skilled Nursing Care when provided by a 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. Therapies must be part of the home care plan and will apply toward the Member's therapy benefits as outlined in the Summary 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 12 months or less; care is provided by a licensed hospice care 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

For adults (19+) that are certified by a physicians or audiologist as deaf or hearing impared Physicians Plus will cover one base/standard hearing aid up to $400 per ear, replaceable every 36 months. This amount will not apply to the Policy maximum out-of-pocket amounts.

For children (0-18) that are certified by a physician or audiologist as deaf or hearing impaired Physicians Plus will cover one hearing aid per ear replaceable every 36 months. Deductibles, Coinsurance and Copays may apply.

Hearing aids must be prescribed by a physician or an audiologist licensed under Wisconsin law consistant with accepted professional medical or audiological standards and purchased through a DME or hearing aid vendor. 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 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 and 2 above. 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 Summary of Benefits. Diagnostic services, treatments and on-going monitoring will apply toward the applicable limitations and exclusions. All services provided after the maximum dollar limit has been covered by Physicians Plus is 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 Maximum Benefit outlined in Your Summary 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 services and/or related complications, if the benefit is NOT listed on Your Summary of Benefits and this Medical Certificate, including but not limited to: artificial insemination (ANY); direct intrauterine insemination (DIUI); 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 infertility services related to surrogate mother services.

INSULIN AND DISPOSABLE DIABETIC SUPPLIES

Physicians Plus will cover: Formulary insulin and diabetes supplies when purchased from a licensed provider or pharmacy; and Physicians Plus-approved diabetes self-management and educational programs.

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 Summary 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 Summary of Benefits. Insulin infusion pumps are limited to the purchase of one pump per Calendar Year (longer if the replacement is covered under

the manufacturers warranty). 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 Calendar 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 Deductible, Coinsurance, Copayments and maximums identified in Your Summary 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; 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.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 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. Prior Authorization is required for all inpatient admissions. Please contact Our Member Service department prior to Your hospitalization so that We can monitor and coordinate Your care and benefits as well as 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.

All services for the mother and the newborn must be Prior Authorized by Physicians Plus before services are rendered; services that are not a covered benefit will not be covered under this provision of the policy and/or authorized for coverage.

MEDICAL SERVICES

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

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

- 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;
- Botox Injections, 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 AND DURABLE MEDICAL EQUIPMENT INCLUDING PROSTHESES

Rentals and purchases of of Medical Supplies and/or Durable Medical Equipment (DME) that exceed the specific dollar amount indicated in your Summary of Benefit require Prior Authorization. ALL limb prosthetics, Continuous Positive Airway Pressure (CPAP) rentals and purchases require Prior Authorization regardless of the rental or purchase amount.

Physicians Plus will cover Medically Necessary Medical Supplies and/or DME and/or Prostheses up to the limits of the Policy when: prescribed by a Provider and purchased for the treatment of an Illness or Injury when a documented functional impairment exists (psychological reasons do not represent a medical/surgical necessity).

A Pharmacy Provider is not a Medical Supplier or DME Provider or vendor for Medical Supplies, DME and Prostheses.

LIMITATIONS: Supplies and equipment including prosthesis are limited to the base model as determined by Physicians Plus. Members may self-pay for upgrades to equipment beyond the base model if desired. Base model electric scooters are covered only when established Physicians Plus criteria is met for needing a scooter rather than other covered power mobility devices.

Coverage for consumable supplies is limited to a 30-day supply or period of use; coverage for prosthetics is limited to one Per Member Per Calendar Year (repairs will be covered based on medical necessity; coverage for compression stockings is limited to 2 pair per Member per Calendar Year; post mastectomy bra and custom made breast Prostheses and Supplies are limited to 2 per Member per Calendar Year; shoe lift(s) are limited to 2 pair per Member per Calendar Year; prothesis related stump stockings are limited to 4 per Member per Calendar Year; custom made foot orthotics are limited one orthotic per affected foot every 36 months; other limitations may apply.

All supplies and/or equipment are subject to any Deductible, Coinsurance, Copayments and maximums outlined in Your Summary 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 and CPAP equipment
- TENS units
- Splints, crutches and braces
- Hospital beds (standard model and size);
- Respiratory/Respiration equipment
- Wheelchairs and other mobility devices
- Leg Braces
- Compression Stockings (limited to 2 pair per Member per Calendar Year).

Physicians Plus will NOT cover the following DME and/or Prostheses services, supplies, and equipment:
- Comfort, Convenience or personal hygiene items, including but not limited to: air cleaners, air conditioners, humidifiers, physical fitness equipment, Physician's equipment, tanning beds, whirlpools, swimming/soaking pools, hot tubs, sauna's, alternative communication devices, Disposable Supplies, transfer and standing equipment (including standers), self help devices and equipment not medical in nature;
- Cranial Orthotic helmets;
- Disposable and/or over-the-counter 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;
- Enteral feeds and/or Disposable Supplies including but not limited to: pumps, bags, tubing, non-prescription or over-the-counter enteral feeds/supplements; nutritional supplements; or vitamins.
- Equipment, models, or devices that have features over and above that which is Medically Indicated (members may self-pay for upgrades to equipment beyond the approved base model if desired);
- Eye glasses, lenses or frames and fittings, except as specifically listed in this Policy;
- Home-testing devices, monitoring supplies and related equipment (i.e. blood pressure monitors, home defibulators etc), except those used in connection with the treatment of diabetes;
- Lost, stolen, back up supplies, equipment and Prothesis;
- Motor vehicles, wheelchair lifts, scooters (except if criteria are met) and stair lifts;
- Not Medically Indicated;
- Over-the-counter supplies, including but not limited to, shoes, splints and/or Orthotics that are NOT custom made and/or can be purchased over-the-counter;
- Purchased, Rented or leased, or modifications to, residence equipment, employment or work equipment including but not limited to motor vehicles;
- Repairs and replacement of equipment and supplies unless Prior Authorized by Physicians Plus; this includes but is not limited to replacements when out of the service area;
- Routine periodic maintenance and/or battery replacements;
- Work, athletics, or job enhancement related.

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 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 36-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 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 reha bilitation 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 licensed 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 Calendar Year for outpatient physical, speech, occupational and rehabilitative therapy (including LIMITED Biofeedback). A copayment may apply, please refer to your Summary 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 and 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 (except Autism) services are limited to one evaluation visit and up to a maximum of 3 visits per therapy (physical, speech and occupational) per Member per Calendar Year. Any treatment beyond the one evaluation visit and 3 therapy visits per therapy, per Member, per Calendar Year is not covered under this Policy.
3. Speech and hearing screenings or examinations are limited to the routine screening tests performed by a 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:
9. Long-Term and/or Maintenance Care/Therapy;
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 employer group administrator. Non-group plans DO NOT include prescription drug coverage unless approved as a rider.*

When drug coverage is approved and purchased, Physicians Plus will cover drugs that: by law require a written prescription; are prescribed by a Provider for treatment of a diagnosed Illness or Injury; and are purchased from a pharmacy.

All prescription drug benefits are subject to the applicable benefit, Deductible, Copayment and/or Coinsurance and Maximums per Member per Calendar year as shown in the appropriate Drug and/or Medical Summary of Benefits.

Prior Authorization (PA) is required for some medications and ALL Biopharmaceuticals. Formulary status is subject to change, see our website at www.pplusic.com, GO-TO Rx Manager or contact Physicians Plus Pharmacy Services department at (608) 260-7803 or (800) 545-5015 for a current formulary and/or list of drugs requiring prior authorization. The following drugs are offered at $0 cost-sharing when applicable: Chlorpheniramine, Fluoride Supplements (Age 6 mo.– 6 yrs), Folic Acid (Women under 42), Prenatal Vitamins (Women under 42), Guaifenesin/Codeine Syrup, Iron Supplements (Age 6-12 months), Naphcon-A eye drops, Nasalcrom Nasal Spray, Niacin (not 120mg SR), Opcon A eye drops, Pseudoephedrine (not 120mg SR), Zaditor (ketotifen).

Physicians Plus maintains a Drug Formulary as a guide for Physician prescribers of self administered 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. 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*. 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. All biopharmaceutical drugs require prioir authorization. Medications classified as biopharmaceuticals are identified on the Physicians Plus drug formulary. 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*.

Pharmacological products for tobacco cessation, as selected by Physicians Plus, that are prescribed by a 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 Calendar 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 Summary of Benefits for details about YOUR Plan.

Certain Formulary and Biopharmaceutical Drugs may require Prior Authorization before being obtained from a pharmacy. If Prior Authorization is approved, the appropirate lower costsharing will apply. If the Prior Authorization is denied or not obtained, the member will be responsible for payment in full or payment at the higher costsharing or tier level (this is dependent on your drug coverage). You may contact the Prescribing Physician or a 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 Summary 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 pack age, 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 and/or Coinsurance ill be charged per monthly cycle. Oral contraceptives may be obtained in a quantity of 3 cycles with appropriate Copayment or Coinsurance per cycle. The following products will be covered at a $0 copay when prescribed and drug coverage is in place:
   - A. Tier 1 formulary oral contraceptives
   - B. Ortho-Tri-Cyclen Lo and Ella
   - C. Ortho Evra Patch and NuvaRing
   - D. Diaphrams

   The following over the counter products WILL NOT be covered:
   - A. Spermicideal gels
   - B. Sponges
   - C. Condoms
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. Refer to the Physicians Plus web site maintains a current version of the Drug Formulary at *www.pplusic.com.*
5. Branded generic drugs, which are sold as brand drugs by the manufacturer, have a brand Copayment or coinsurance amount. Refer to Your Drug Summary of Benefits for an explanation of Deductible, Coinsurance, Copayments and maximums related to Your Plan.
6. Maintenance drugs (on the Physicians Plus maintenance drug list) can be dispensed in a 90-day supply for the applicable monthly cost sharing as stated on your Drug Summary of Benefits (i.e. 90 days = 1, 2 or 3 copays-depending on 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.
2. Medications used for cosmetic purposes; sexual dysfunction; or weight loss or the treatment of obesity or morbid obesity, including improvement of other co-morbid health conditions that may benefit 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. Neutri-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.

PREVENTIVE CARE AND SERVICES

Physicians Plus will cover preventive services mandated by the State of Wisconsin and Federal requirements. Cost sharing may apply to some or all services please refer to your Summary of Benefits and Medical Certificate of Coverage. **Cost sharing will apply when services are provided by a non-Participating provider.** If other (non-preventive) services are provided at the time preventive services are performed, cost sharing will also apply.

We are not able to list every code for every service covered under the preventive benefit. The following are the TYPES of services covered by your policy in compliance with the Federal health care reform mandate:

1. Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommenda tions of the United States Preventive Services Task Force (USPSTF);
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
3. Infants, children, and adolescents, evidence informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. Women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The following list identifies the preventive services covered by your Policy. Please refer to your Summary of Benefits to determine if cost sharing applies. **Cost sharing will apply when services are provided by a non-participating provider.**

MOST COMMON PREVENTIVE SERVICES:

Annual Routine Exams
Annual Well Woman Exam
Well Child Exam - Ages 0-17
Annual Vision Exam - Any age
Mammogram Screening - Any age
Children Lead Screening - Ages 0-17
Routine Child Immunizations - Ages 0-17

OTHER PREVENTIVE SERVICES:

1. Abdominal Aortic Aneurysm Screening - Men 65-75
2. Alcohol misuse Screening & Counseling
3. Aspirin Counseling to prevent cardiovascular event - Men 45-79; Woman 55-79
4. Breast Cancer Genetic Evaluation and Testing - High Risk Woman (Prior Authorization required)
5. Breast Feeding Counseling
6. Cervical Cancer Screening
7. Child & Adult Vaccines (Toxoids)
8. Chlamydia Screening
9. Colorectal Cancer Screening//Screening colonoscopy & flexible sigmoidoscopy only
   (Virtual Colonoscopies are only covered when a normal colonoscopy cannot be done due to safety or potential lack of effectiveness as determined and authorized by Physicians Plus)
11. Counseling to prevent sexually transmitted disease
12. Depression screening
13. Diabetes screening
14. Floride (dental benefit) - Children 6 months to 6 years old

15. Gonnorrhea Screening - Woman only
16. Healthy Diet Counseling
17. Healthy Pregnancy Screening for Pregnant woman normally under age 42: Alcohol, Anemia, Asyptomatic Bacteriurial, Gonorrhea, Hepatitis B, HBV, HIV, Immunizations, Rh(D), Rubella, Syphillis, Tobacco use screenings and Folic Acid Supplements.
18. HIV Screening & Counseling
19. Hypertension Screening & Counseling
20. Iron Deficiency Anemia - Screening & Supplements - Only when you have drug coverage with Physicians Plus
21. Lipid Disorder Screening
22. Newborn Screenings for newborns: Hearing, Hemoglobin, Hypothyroidism, Phenylketonuria (PKU), Vision.
23. Obesity Screening & Counseling
24. Osteoporosis Screening - ages 60 and over
25. Syphilis Screening
26. Tobacco use Screening & Counseling
27. Vaccine Administration & Counseling
28. Vision Screening - children ages 0-5

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.

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 Summary of Benefits, Physicians Plus will cover Medically Indicated surgical procedures for the treatment of an Illness and/or Injury. Surgical services may include some injections (pain injections, surgical block injections etc) that are considered surgical procedures. If you have Questons please consult with the provider of services.

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

Most Medically Indicated Outpatient Surgical Services do not require Prior Authorization. However, if the surgical procedure/service could be considered cosmetic in nature (e.g. mammoplasty, rhinoplasty, male gynecomastia, panniculectomy) the Member is encouraged to ask the Provider to send us information to obtain Prior Authorization.

Prior Authorization includes the Provider and the location at which certain services and supplies must be obtained in accordance with the Physicians Plus Medical Management Program.

The following 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 and there will be marked improvement of a functional deficit that significantly interferes with activities of daily living.

(C) Emergency treatment of traumatic injuries (e.g. facial lacerations, amputation).

(D) When plastic or reconstructive services are incidental but required to remove pathologic tissue (e.g. skin cancer).

(E) 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 connect tion 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.

(F) Cochlear Implants and related services to correct total deafness. 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.
(G) Botox Injections when the patient meets Physicians Plus criteria for coverage and the therapy is Prior Authorized by Physicians Plus.
(H) Work, athletics, or job enhancement related.

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 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, liposuction and 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; 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 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 and meet transplant criteria 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. Except for corneal, bone marrow and kidney, transplants are limited to the initial transplant of the original organ per member per year and are subject to the annual maximum benefit of $2,000,000 for all transplants (except kidney transplants, the coverage for which is discussed in the BENEFITS AND SERVICES-KIDNEY DISEASE/TRANSPLANT section of this Certificate).

All transplant-related treatment, services and supplies will be applied to the members transplant annual limit, including but not limited to: testing, procurement, procedures post and pre-transplant, drugs and medications while confined in a Hospital or medical facility, including post-transplant take-home drugs (one time only).

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 annual benefit maximum of the Policy.

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 treatments, 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. Bone Marrow transplants are not limited to one per member per lifetime.

(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.

Physicians Plus will not cover

- Transplants and related expenses, except those outlined as covered procedures in this Certificate or Your Summary of Benefits;
- The purchase of an organ;
- Storage of blood, tissue, cells or any other body fluids;
- 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 Calendar Year; and one standard monofocal (single-focal) lens (contact or frame) per surgical eye as part of cataract surgery.

Physicians Plus will not cover services not indicated as covered above; procedures to correct myopia, hyperopia and astigmatism, including but not limited to: laser photokeratotomy; laser keratectomy; refractive keratoplasty; radial keratectomy; keratotomy; excimer laser photorefrative 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 for which Prior Authorization was required but not obtained. It is the Member's responsibility to obtain the proper Prior Authorizations. For a complete list of Prior Authorization requirements, please visit www.pplusic.com and click on Member then Member Materials or contact Our Member Service department at (608) 282-8900 or (800) 545-5015.
b. 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.
c. Paternity testing.
d. Cytotoxic testing in conjunction with allergy testing.
e. Hair analysis, unless lead or arsenic poisoning is suspected.
f. Coma stimulation programs.
g. Orthoptics (eye exercise training).
h. Long Term and/or Maintenance Care/Therapy.
i. Massage therapy (except when provided during physical therapy for an Acute Illness or Injury).
j. One second opinion by a Non-Participating Provider (HMO ONLY).
k. 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).
l. Charges for telephone consultations by and between Providers.
m. Charges for any missed appointments.
n. Expenses for medical records and/or reports, including but not limited to, the preparation and presentation of these reports.
o. Chelation therapy for arteriosclerosis.
p. 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.
q. Services and supplies that are not Medically Indicated and/or are not appropriate or the standard of care to treat the Illness or Injury, as determined by Physicians Plus.
r. 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).
s. 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.
t. 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. This exclusion does not apply to liability insurance policies (coverage commonly referred to as "medical payments" or "med pay expenses" are not a liability insurance policies and are covered by this exclusion). 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.
u. 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.

v. 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 Workers 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.
w. Treatment and services furnished by the U.S. Veterans Administration except when coverage is required under applicable federal law.
x. 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.
y. 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. This does not include services or treatment of injuries that result from a medical condition (such as depression) or from an act of domestic violence.
z. Reconstructive Surgery/Cosmetic Treatment, except as indicated in this Policy. (NOTE: Psychological reasons do not represent a medical or surgical necessity.
aa. 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.
bb. Injection of filling material such as collagen, salabrasion, rhytidectomy, dermabrasion, chemical peel.
cc. Suction-assisted lipectomy.
dd. Hair Removal.
ee. Mastopexy*.
ff. Augmentation mammoplasty (unless You meet the Physicians Plus medical policy criteria)*;
gg. Correction of inverted nipples*;
hh. Reduction mammoplasty (unless You meet the Physicians Plus medical policy criteria)*;
ii. Sclerosing of spider veins.
jj. Panniculectomy (unless You meet the Physicians Plus medical policy criteria);
kk. Mastectomy for male gynecomastia (unless You meet the Physicians Plus medical policy criteria)*;.
ll. Experimental, Investigational, Emerging Technology 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).
mm. Any treatment, service or supply that is received in a Hospital emergency room (whether received from a Participating Provider or non-Participating Provider) that does not meet the definition of Emergency Medical Care.
nn. 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).
oo. Hypnotism, goal-oriented behavioral modification, and biofeedback; Acupuncture (unless You meet the Physicians Plus medical policy criteria. SEE BENEFITS and SERVICES SECTION).
pp. Treatment, services and supplies for holistic or homeopathic medicine, or programs that are not accepted medical practice as determined by Physicians Plus.
qq. Treatment, services and supplies for, or leading to, sex-transformation surgery and sex hormones related to such treatment.
rr. Take-home drugs and outpatient prescription drugs not specifically covered under this Policy.
ss. 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, liposuction and 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;
tt. Nutritional supplements and/or vitamins;

uu. Lodging expenses.

vv. Transportation expenses (except for covered ambulance transport as outlined in the benefits sections of this Policy).

ww. 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.

xx. Autopsy services.

yy. Treatment, services and supplies for which the Member has no obligation to pay.

zz. Amounts in excess of the Usual and Customary charge for the covered service, treatment or supply.

aaa. Services, supplies and costs (including re-admission) related to services obtained and/or repeated when a member discharges themselves and/or leaves a facility/clinic against medical advice as determined by the Physician and Physicians Plus.

bbb. Storage of blood, tissue, cells or any other body fluid.

ccc. Sexual dysfunction treatment, services, supplies and drugs including but not limited to implants, penis pumps, vacuum devices, over the counter and prescription drugs.

ddd. Removal of Skin Tags.

eee. Coverage for Keloid Scar revision/removal (unless You meet the Physicians Plus medical policy criteria).

* 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 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. 6.51 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.

Eligible Dependents include any of the following who meet the other requirements of the Policy (such as age limits): a covered employee's spouse; a dependent child, stepchild, adopted child, or Legal Ward who is under age 18; grandchild (so long as the grandchild's parent is a covered dependent and under age 18); a child placed for adoption with the Eligible Employee; and an adult child who is under the age of 26.

Wisconsin and Federal law requires Us to also provide coverage of the child of an applicant or an insured if the child is a full time student after being called to active duty in the National Guard or a reserve component of the U.S. Armed Services when he/she was a full-time student under the age of 27. Maximum dependent age means under age 26 (except for those under the preceeding sentence).

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.

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 adult child returns from serving in the military and becomes a Full-Time Student IF the adult 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 RULES FOR NEWBORNS, ADOPTED CHILDREN AND CHILDREN PLACED FOR ADOPTION

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.

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

If You are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If You or Your dependents are already enrolled in Medicaid or CHIP You can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Wisconsin information: Website: http://www.badgercareplus.org/pubs/p-0095.htm or phone: 1-800-362-3002.

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.

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.

An adult child 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.

An adult child 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 adult child 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 adult child advises Us that he or she does not intend to return to school full time.
2. The adult child becomes employed full time.
3. The adult child obtains other health care coverage.
4. The adult child marries.
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 adult child special continuation coverage under this provision began and the adult child has not returned to school full time.

7. OTHER POLICY PROVISIONS

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.

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 of the 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.

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 whether 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 correct 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.

Foreign claims: To submit payment for services received outside of the country you must submit an itemized bill in english. We will pay the exchange rate for the specific date of service or discharge date to the member when the services were paid for by the member. The member must submit proof of payment.

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.

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.

ENTIRE CONTRACT/CHANGES

The Policy (including the Group Master Policy, this medical Certificate, Summary 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.

LIMIT ON ACTIONS

An action under this policy must be commenced within 3 years from the date the written proof of loss is required to be filed.

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.

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.)

MEDICAL MANAGEMENT PROGRAM

Physicians Plus operates a Medical Management Program with the dual goals of our members receiving high quality care and appropriately controlling our members' and their groups' costs. The Medical Management Program consists of a Utilization Management ("UM") Program and a Quality Management ("QM") Program

The Physicians Plus UM Program is designed to demonstrate accountability to the Plan's enrollees and employer groups through active monitoring and managing of health care resources across the full continuum of care. The goal of the program is the delivery of cost-effective, quality health care.

Physicians Plus is committed to improving the health status of the Plan's members and to reducing acute care needs through anticipatory care management. In addition, the UM Program provides a systematic method to manage the utilization of services provided through Physicians Plus.

The management of services is achieved through the ongoing monitoring and evaluation of medical necessity, the appropriateness of the level of care, the place of service, the provider of service, adequacy of access to resources and benefit levels.

The UM program is implemented in conjunction with the QM Program, which is designed to identify and promote optimal clinical practices in all settings. The Program includes requirements for Prior Authorization of certain medically necessary services and supplies. The Program also includes requirements for certain services or supplies to be provided at designated locations or with designated Providers. Exceptions to those requirements would require Prior Authorization.

The Medical Management Program is amended from time to time by Physicians Plus and is provided to Participating Providers. Member responsibilities to obtain required Prior Authorizations for certain non-emergency services are identified in this Medical Certificate and also may be communicated to Members through written, web-based and verbal mechanisms.

NEW TECHNOLOGY DETERMINATION

New technologies and new applications of existing technologies are evaluated and approved for coverage when they are scientifically proven to be safe and effecious; provide a demonstratable benefit for a particular illness or disease; and there is no equally effective or less costly alternative.

Process: Plan-developed standards guide the evaluation process to assure appropriate coverage determinations. Emerging and innovative technologies are monitored by Physicians Plus through review of trend reports from technology assessment bodies; government publications; and information provided by providers and professional societies.

A systematic process for evaluating a new technology or new application of an existing technology is initiated when sufficient scientific information is available through a medical literature review.

A core committee of health plan staff and physician specialists, as well as external practicing providers and/or pharmacists, evaluate and recommend coverage for new technologies. Their decisions are based on information provided by expert opinions, current medical literature including clinical trials and recognized clinical guidelines, recommendations of national organizations and technology assessment bodies, and governmental requirements and regulations. Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

New technology must minimally meet the following guidelines to be approved for coverage.

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more than established alternatives, and should be equally or more cost-effective than comparable alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions which are based on established medical facts.
- Opinions and evaluations of professional organizations, panels or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

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 Physician (PCP); or
b. 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;
c. A Provider/Physician other than a Participating Provider when a Member requires Emergency Medical Care;

d. A Hospital when referred by a Physician as described in (a), (b), (c), or (d) above and Prior Authorized by Physicians Plus. In addition, in order to be covered, any required Prior Authorization must be approved by Physicians Plus.

   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 Plu's is obligated to provide only the benefits specifically stated in 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: (1) 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 (2) 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.

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 it's 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.

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.

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. Any time a member receives a settlement that is less than available insurance limits, the member shall be deemed to have been made whole.

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.

UNCONTROLLABLE CIRCUMSTANCES

If circumstances beyond Our reasonable control delay or prevent the rendering of any covered treatment, service or supply by 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 the Providers, and other causes beyond Our reasonable control.

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.

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".

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, that should have been paid under this Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" 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 last day of the calendar month for which the Member's premium contribution, if any, has been paid;
(D) The date a Member enters into military service, other than for duty of less than 30 days;
(E) 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;
(F) 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;
(G) For an employee's spouse and/or other dependent who is a Member, the date the employee's coverage terminates;
(H) For the employee's spouse, the date the employee's spouse is no longer married to the employee due to divorce or annulment;
(I) For the employee's Eligible Dependent child, stepchild, adopted child, or child Placed for Adoption with the employee, the end of the day (12:00 midnight) when the child exceeds the Maximum Dependent age (generally 25, but see definition of Maximum Dependent Age).

However, 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 handicapped (ii) chiefly dependent upon the covered employee for support and mainte nance. In that situation the adult child may remain eligible under Family Coverage beyond the Maximum Dependent age. Physicians Plus will work with the employee, the adult 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.

Coverage may continue for an adult child if he/she is 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 when he/she was a Full-Time student under the age of 27 (see "EFFECTIVE DATES AND ELIGIBILITY" section of this certificate).

(J) For the grandchild of the covered employee the date that the grandchild's parent reaches age 18 or otherwise loses coverage;
(K) The date a Member is disenrolled as described in any section of this Policy; and
(L) 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 committed acts of physical or verbal abuse that pose a threat to Providers or other Physicians Plus Members;
(C) 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;
(D) The Member is unable to establish or maintain a satisfactory physician-patient relationship with the Member's PCP; or
(E) Physicians Plus has not renewed the Policy; or
(F) The Member establishes residence outside of the Service Area.

Disenrollment for reason (D) 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 (B), (C) or (D) 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).

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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (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. A copy of our grievance and independent process is available at www.pplusic.com/member materials/appeals or upon request by calling our Member Service Department at (608) 282-8900 or (800) 545-5015.

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 verbal Complaint will be documented and investigated. If Your Complaint is not resolved to Your satisfaction, You (or an authorized representative) may file a Grievance with Physicians Plus.

GRIEVANCES AND INTERNAL APPEALS PROCESS

A Grievance IS defined as any dissatisfaction that is expressed in writing to Us by or on behalf of You, including dissatisfaction with Our services, Our claims practices or an Adverse Benefit Determination.

"Adverse Benefit Determination" means any of the following:

- a recission of Your coverage (whether or not the recission has any effect on any particular benefit at that time);
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

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
2650 Novation Parkway
Madison, WI 53713

Except for an "Expedited Grievance" (defined 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, You (or an authorized representative) will have the right to participate in, and provide testimony at, the Grievance hearing or attend by teleconference. You also have the right to submit written comments, documents, records and other information relating to Your claim for benefits. Upon request, We will provide You with reasonable access to, and copies of, all documents, records, and other information relevant to the Adverse Benefit Determination that is the subject of your Grievance. We conduct our Grievance process in accordance with the requirements of the federal Patient Protection and Affordable Care Act, as amended, 45 CFR 147.136, and Wisconsin law.

If You choose to participate (or have Your authorized representative participate) in the Grievance 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 involving a post-service claims, 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 soon as possible, taking into account Your medical exigencies, 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, as determined by either Your attending provider or Us:

1. The duration of the standard Grievance process could seriously jeopardize Your life or health or Your ability to regain maximum function; or
2. You are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance.

If You fail to provide Us sufficient information to determine whether, or to what extent, benefits are covered or payable under Your Policy, We will notify You of that fact as soon as possible but not later than 24 hours of your request for Expedited Grievance and allow You at least 48 hours to provide Us the necessary information.

You may request review of an Expedited Grievance either in writing or orally. You should immediately contact (or have Your Physician immediately contact) the Physicians Plus Appeals Administrator at (608) 417-4526 or our Member Service Department at (608) 282-8900 or (800) 545-5015 and clearly identify Your request as an "EXPEDITED GRIEVANCE,".

INDEPENDENT REVIEW PROCESS

The independent review process gives You the opportunity to have peer review professionals, who have no connection to Physicians Plus, review an Adverse Benefit Determination that is based on: (a) a medical judgment (including medical necessity, appropriateness, health care setting, or level of care or effectiveness of a covered benefit or that the treatment is Experimental), as determined by the independent reviewer; or (b) a denial of Your request for services from a non-Participating Provider when You believe that the clinical expertise of the non-Participating Provider is medically necessary (not applicable pays off panel); (c) Our denial of coverage based on a preexisting condition exclusion; or (d) Our rescission of coverage (whether the rescission has any effect on any particular benefit at that time). For multiple family Member Grievances, each Member must meet the criteria. The treatment or services must otherwise be a covered benefit under Your Policy.

You generally must complete Our internal Grievance process before requesting independent review, and You or Your authorized representative must request an independent review within 4 months from receipt of the Grievance committee's decision approving the Adverse Benefit Determination. You do not need to exhaust Our internal Grievance process when We do not meet Our internal Grievance process timelines (except for certain de minimus violations that do not cause, and are not likely to cause, prejudice or harm to You) or when You or your authorized representative simultaneously requests an Expedited Grievance and an expedited independent review.

The following Federal Review process must be followed when requesting an Independent Review.

The Federal External Review Process administered for the U.S. Department of Health and Human Services (HHS) is being implemented by MAXIMUS Federal Services, Inc. This is referred to as the HHS-Administered Federal External Review Process.

The Affordable Care Act requires many health plans to meet basic standards regarding internal and external review processes. Consumers now have rights to appeal health insurance plan decisions – to ask that health plans reconsider decisions to deny payment for services or treatments.

Consumers also have a right to an independent third-party review of a denial by their health insurance plan. The Federal External Review Process allows for an independent, outside review of adverse benefit decisions by health plans. Adverse benefit determinations may include denials for authorizing care or refusals to pay for services already performed.

Consumers or their authorized representatives have the right to ask health insurance plans to look at their adverse benefit determinations again. This is called an internal appeal. If the plan denies the payment or service after the internal appeal, it will issue a final internal adverse benefit determination. The law allows the consumer to ask for a review of this final internal adverse benefit determination by an independent third party. This is an external review.

In some cases, a consumer can request an external review of the original adverse benefit determination to deny a benefit or refuse payment.

The purpose of the external review is to determine if the decision made by the health plan was supported or not.

There is a standard external review and, for urgent cases, an expedited (faster than usual) external review is conducted. The external review can be for adverse benefit determinations that involve:

- Medical necessity
- Appropriateness
- Health care setting
- Level of care
- Effectiveness of a covered benefit
- Whether a treatment is experimental or investigational
- Any other matter that involves medical judgment

If your health insurance is retroactively cancelled, this may also go to external review. This is often referred to as a rescission of coverage.

Finally, if your application for individual health insurance is denied, this may also go to external review.

A person may submit a standard external review request via mail, fax, or submit an online request for an external review within months after the date the consumer received the final internal adverse benefit determination notice.

To request an external review, please submit the online form which can be found at www.externalappeals.com, or the following information:

- Name
- Address
- Phone
- Email address
- Whether the request is urgent
- Patient's signature if person filing the appeal is not the patient
- A brief description of the reason you disagree with your plan's denial decision
- You may use an HHS Federal External Review Request Form to provide this and other additional infor mation.
- Also, a person may submit additional information for consideration of their external review request. For example, a person may provide: Documents to support the claim, such as physicians' letters, reports, bills, medical records, and explanation of benefits (EOB) forms;
- Letters sent to your health insurance plan about the denied claim; and
- Letters received from the health insurance plan.

Instructions for Sending Your External Review Request:

You may mail a request for external review to the address listed on your final adverse benefit determination (denial) letter from your health insurance issuer, or you may mail your external review request directly to MAXIMUS:

By Mail: MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
By Fax: 1-888-866-6190
Online FORM www.externalappeal.com

The MAXIMUS Federal Services examiner will contact the health insurance plan once we receive the request for external review. Within five business days, the plan must give the examiner all documents and information used to make the final internal adverse benefit determination. The MAXIMUS examiner must give the claimant written notice of the final external review decision as soon as possible, but no later than 45 days after the examiner receives the request for an external review.

EXPEDITED REVIEW
In some cases, a person may ask for an expedited (faster than usual) external review. An expedited review may be requested when:

1. The person has asked for an expedited internal appeal and wants an expedited external review at the same time, and the timeframe for an expedited internal appeal (72 hours) would place the person's life, health or ability to regain maximum function in danger; or
2. The person has completed an internal appeal with the plan and the decision was not in his or her favor, and:
   a. The timeframe to do a standard external review (45 days) would place the person's life, health or ability to regain maximum function in danger, or b. The decision is about admission, care availability, continued stay, or emergency health care services where the person has not been discharged from the facility.

When requesting an expedited external review, a person must provide the following information:
- Name and Address
- Phone
- Email address
- Whether the request is urgent
- Patient's signature if person filing the appeal is not the patient
- A brief description of the reason you disagree with your plan's denial decision
- You may use an HHS Federal External Review Request Form to provide this and other additional infor mation.
- An expedited external review happens faster if a person asks for it by calling the Maximus toll-free telephone number: 1-888-866-6205.

The 72-hour timeframe for an expedited request begins when the phone call ends.
Instructions for Sending Your Expedited External Review Request:

A person may also ask for an expedited external review by mail or fax. The 72-hour timeframe for expedited requests sent by mail or fax begins when the request is received.

By Mail: MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
By Fax: 1-888-866-6190

The MAXIMUS Federal Services examiner will contact the health insurance plan immediately upon receipt of the request for external review. The plan must give the examiner all documents and information used to make the internal adverse benefit decision as expeditiously as possible.

The MAXIMUS examiner will give the claimant and the health plan the external review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request. The MAXIMUS examiner can give the external review decision orally, but it must be followed up by a written version of the decision within 48 hours of the oral notification.

GENERAL QUESTIONS & ANSWERS

1. What is the External Review Process? The External Review Process gives you the right to an independent, third-party review when your health insurance plan denies care or refuses to pay for care you already received. Under the Affordable Care Act, health insurance issuers in certain States (which have not met minimum consumer protections in their external review process) may choose either: the HHS-Administered Federal External Review Process, or they may contract with accredited Independent Review Organizations (IROs) to review external appeals on their behalf.

2. Under the HHS-Administered Federal External Review Process, who may request external review? A consumer (or patient) or their authorized representative may request an external review.

3. When can I request an external review? A consumer (or their authorized representative) must request an external review within 6 months of receiving a final internal adverse benefit determination notice from their health plan or issuer.

4. Are there times when I can request a simultaneous internal appeal and external review? Yes, you may request a simultaneous internal appeal and external review:

   When an adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

   When a final internal adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

   When a final internal adverse benefit determination concerns the admission, availability of care, contin ued stay or health care service for which the claimant received emergency services but has not yet been discharged from a facility.

5. How can I appoint an "authorized representative" for my external appeal? You can designate an authorized representative (such as your physician) to request an external appeal by completing an "Appointment of Representative" Form. You must complete and sign Section 1 of the form and the individual you are appointing must complete and sign Section 2 of the form. You should keep a copy of the signed form and include the signed original with your review request.

   The HHS-Administered Federal External Review Process "Appointment of Representative" Form is available by fax or e-mail request, and it is available at: www.externalappeal.com.

   In addition, your health plan or issuer, or Consumer Assistance Program in your home State may have an Appointment of Representative form. If so, you may submit a copy of that form with your request for external review (provided all the information required by the HHS form is contained in this form).

6. Can a provider submit an external appeal on its own behalf? No. A provider may not submit an external appeal directly, but may serve as an authorized representative for a patient.

7. How much does an external review cost under the HHS-Administered Federal External Review Process? There is no cost to you or the insurer.

8. Who operates the HHS-Administered Federal External Review Process? MAXIMUS Federal Services, Inc. was selected as the independent, third party reviewer to operate the HHS-Administered Federal External Review Process.

9. Who conducts the external review? MAXIMUS has a group of experts, including lawyers, doctors, nurses and other consultants, who conduct the external review.

10. How can I ask for an external review under the HHS-Administered Federal External Review Process? You can mail or fax a written request for a standard external review. Starting soon, you will also be able to use a secure web-based portal to request a standard external review.

You can ask for an expedited external review by calling the toll-free telephone number: 1-888-866-6205.

You can ask for an expedited external review by mail or fax. You can mail a request to the address listed on the notice provided by the health insurance issuer denying benefits or you can mail your request directly to MAXIMUS.

By Mail: MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
By Fax: 1-888-866-6190

11. Can I ask for an external review by phone? Only requests for expedited (fast) external review can be made by phone. Standard requests must be submitted in writing (mail or fax) or online (starting soon).

12. How long does it take MAXIMUS to make an external review decision for the HHS-Administered Federal External Review Process? For a standard external review, the MAXIMUS reviewer must give you written notice of the decision as soon as possible, but no more than 45 days after the reviewer receives your request for an external review.

    For an expedited external review, the MAXIMUS reviewer must give you and the health plan the decision as quickly as medical circumstances require, but no more than 72 hours of receiving your request. The reviewer can give you an oral decision but must follow up in writing within 48 hours.

13. Where can I get more information about the HHS-Administered Federal External Review Process? You can get more information on this website and at these other websites:

    http://cciio.cms.gov/programs/consumer/appeals/index.html
    http://www.healthcare.gov/law/features/rights/appealing-decisions/

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
125 South Webster 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 file a timely 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.

A copy of our grievance and independent process is available at www.pplusic.com/member materials/appeals or upon request by calling our Member Service Department at (608) 282-8900 or (800) 545-5015.

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. 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

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" (PHI). PHI 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.

Workers Compensation: We may use or release protected health information to comply with workers 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. If PHI is shared with the employer, we prohibit the use of PHI by the employer or plan sponsor for employment or other benefit-related decisions.

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
2650 Novation Parkway   or   ppicinfo@pplusic.com
Madison, WI 53713

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.

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 per sonal 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.

Adverse Benefit Determination means any of the following:

- a recission of Your coverage (whether or not the recission has any effect on any particular benefit at that time);
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimen tal or investigational or not medically necessary or appropriate.

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.

Base Benefit(s) when enrolled in the *HealthyGoals* product means higher costsharing as for members who do not comply with *HealthyGoals* requirements.

Behavioral Health includes nervous or mental disorders.

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

Cochlear Implant includes any implantable device that is designed to enhance hearing.

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 verbal 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 birth or 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 illnesss 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.

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.

Dual Choice or Multiple Carrier Choice means one time per year that employees can change between insurance carriers when multiple carriers are offered to employees of one employer.

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 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 and Emerging Technology 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.

Experimental, Investigative, Emerging Technology 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 accord ing to the terms of Your Policy;
3. Based on the information provided, We denied the proposed treatment or payment for the proposed treatment; and
4. The denial of the proposed treatment has been through all levels of the Physicians Plus

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 and Appeals 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.

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

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

Health Maintenance Organization (HMO) means health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific plan or Participating Providers.

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.

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 miscarriages.

Maximum Dependent Age Maximum Dependent Age means less than age 26 or, in the case of the employee's child, stepchild, or adopted child who is a full-time student after being called to active duty in the National Guard or Reserve Component of the U.S. Armed forces when he/she was a full time student under the age of 27, when he/she ceases to be a full-time student.

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 at the particular location or for the particular service.

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.

Open Enrollment means one time per year selected by the employer and approved by the carrier or carriers to offer coverage to any eligible employee to get insurance coverage as long as they are eligible and have met any waiting or probationary period. OPEN ENROLLMENTS must be approved by the health plan(s).

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 non-residential 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 if a Participating Provider:

(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 for that location and for that service.

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 at the location(s) listed in the Provider Directory for physician, other healthcare provider or facility for the particular services at the listed location(s) and for the listed services.

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 Summary 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.

Preexisting 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. Preexisting does not apply to members on an HMO plan.

Preferred Benefit(s) when enrolled in the *HealthyGoals* product means lower costsharing as incentive for members who comply with *HealthyGoals* program requirements.

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.

Prior Authorization or Prior Authorized means a prior written or verbal approval from Physicians Plus of: (1) a specific medical and/or drug treatment, service or supply, (2) the location at which the treatment, service or supply is received, and/or (3) the Participating Provider from whom the treatment, service or supply is received. YOU and the treatment, service or supply also must meet the Policy's other coverage requirements at the time the service or supply is provided.

Prior Authorization requirements may change from time to time as part of Our on-going programs to provide high quality, medically necessary health care services in the most appropriate and cost-effective setting. You can obtain a current and complete list of Prior Authorization requirements by visiting Our website at www.pplusic.com and clicking on Member then Member Materials or by contacting our Member Services department at (608) 282-8900 or 1-800-545-5015.

Private-duty Nursing refers to provision of continuous skilled one-on-one nursing care in the home from registered nurses (RNs) or licensed practical nurses (LPNs).

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.

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.

Summary 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.

Summary of Benefits and Coverage (SBC) - means a required document to be provided to members and employers in accordance with the Affordable Care Act (ACA). The ACA requires insurers and group health plans to provide the SBC in a clear, consistent and comparable information about their health plan benefits and coverage. The format and content is dictated by the ACA.

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: Services for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems that are Medically Indicated at the respective level of care (e.g. residential versus day treatment) and 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); when residential care is Medically Indicated;
(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.

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.

Wellness Plan means "wellness program" as a program designed to promote health, well-being or prevent disease and that meets the required qualifications of wellness programs under federal law relating to prohibiting discrimination against insurance participants and beneficiaries based on a health factor.

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

You, Your means the Member and/or Subscriber.

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