network health

BENEFIT BOOKLET

3738-01-1021

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I. Your Benefit Information

The documents in this section provide details on cost sharing information for your medical and pharmacy benefits.

1. Medical and Pharmacy Summary of Member Responsibility
2. Summary of Benefits and Coverage

II. Coverage Details

The document(s) in this section provides detail of covered services, limitations and exclusions, and other provisions on how to use the health plan.

1. Policy

In your Member Portal you will find a link to the Preventive Services Guide which informs you of the preventive services covered at no member cost share. You will also find the How to Use Your Health Plan member guide to help you navigate your health plan. Also included, is a PDF document containing all applicable notices for your plan.

Please review all these materials carefully to best understand your health benefits and how to utilize them. Should you have any questions, you may contact our Member Experience team at the number found on the back of your ID card.

SILVER INDIVIDUAL AND FAMILY HEALTH PLAN
SUMMARY OF MEMBER RESPONSIBILITY TABLE

This is a summary of what you'll pay for covered medical services and prescription drugs. It is not a complete list of services or costs.

All Benefits are subject to the terms, limitations, and exclusions of the Policy. Please refer to your Policy, Preventive Services Guide, and any applicable Riders for detailed Benefits information, eligible services, and coverage guidelines. Network Health Plan's coverage includes Benefits for all State of Wisconsin and Federal mandated benefits.

This is a Health Maintenance Organization (HMO) plan. Covered Services must be provided by a Network Provider (Participating Provider). Applicable medical and prescription drug copayments, deductible and coinsurance costs apply toward your annual out-of-pocket maximum when the services are provided by a plan participating provider. When medical services are **not** provided by a plan participating provider, they will not be covered. You can search for participating providers at **networkhealth.com**. Non-covered services and denied benefits will not apply toward your out-of-pocket limit.

		You Pay
Annual Deductible *This is the amount of money you must pay before your plan begins paying for covered services.*	**Member**	**$1,500**
	Family	**$3,000**
Coinsurance *This is the percent of the cost you'll pay after you've met your deductible.*		**20%**
Annual Out-of-Pocket Limit *This is the maximum amount you'll pay for covered services and prescription drugs during a plan year. Once this limit is reached, your plan pays 100 percent for all covered services.*	**Member**	**$2,300**
	Family	**$4,600**

Please contact Network Health Plan's Member Experience team at the number on the back of your ID card for assistance in understanding your health care Benefits.

Medical Benefits	What You Pay
Preventive Health	
Preventive Services *Log in to Your account at **login.networkhealth.com** and click on **My Materials** to find a link to the Preventive Services Guide*	No Charge
Adult Routine Vision Exam	No Charge
Pediatric Routine Vision Exam	No Charge
Adult and Pediatric Annual Dental Exams with Cleanings and X-Ray	100% Reimbursement for eligible expenses
Physician and Practitioner Services	
Primary Care Practitioner Home and Office Visits *Including Behavioral Health and Substance Abuse*	1st 3 visits No Charge then $25 Copayment per visit
Virtual Visits	No Charge
Specialist Home and Office Visits	$65 Copayment per visit
Autism Services Intensive and Non-Intensive	20% Coinsurance after Deductible
Primary Care Practitioner Inpatient Visits *Including Behavioral Health and Substance Abuse*	20% Coinsurance after Deductible
Specialist Inpatient Visits	20% Coinsurance after Deductible
All Other Outpatient Services/Procedures Performed in Practitioner's Office not otherwise listed on this table	20% Coinsurance after Deductible
Accidental Dental Services	20% Coinsurance after Deductible
Maternity Care	20% Coinsurance after Deductible
Chiropractic Office Visits and Manipulations	20% Coinsurance after Deductible
Diagnostic Services	

Medical Benefits	What You Pay
Diagnostic Lab and Pathology in Practitioner's Office or Outpatient Facility	$25 Copayment per visit
Lab Tests for Condition Management of Chronic Diseases	$10 Copayment per visit
X-Ray and Diagnostic Imaging in Practitioner's Office or Outpatient Facility	$50 Copayment per visit
PET Scans, MRIs, MRAs, CT Scans and Stress Tests	20% Coinsurance after Deductible
Ultrasounds	$50 Copayment per visit
Echocardiograms	$50 Copayment per visit
Hospital Services	
Inpatient Services *Including Behavioral Health and Substance Abuse*	20% Coinsurance after Deductible
Skilled Nursing Facility	20% Coinsurance after Deductible
Outpatient Behavioral Health and Substance Abuse Services/Procedures	20% Coinsurance after Deductible
Outpatient Services or Procedures *Including Radiation therapy, Dialysis and Surgery*	20% Coinsurance after Deductible
Ambulatory Surgical Center	20% Coinsurance after Deductible
Infusion Services	
Professional (Administration) Fees, Supplies and any other charges	20% Coinsurance after Deductible
Pharmacy charge for medication	Based on formulary and benefit tier in the Prescription Drugs section below
Rehabilitation Services	
Physical/Occupational/Speech Therapy, Cardiac Rehab and Pulmonary Rehab	20% Coinsurance after Deductible

Medical Benefits	What You Pay
Habilitative Services	
Physical/Occupational/Speech Therapy	20% Coinsurance after Deductible
Home Health and Hospice Care	
Home Health Care Services *Including Infusion Services*	20% Coinsurance after Deductible
Hospice Care Services	No Charge
Medical Supplies and Equipment	
Durable Medical Equipment	20% Coinsurance after Deductible
Prosthetic Devices	20% Coinsurance after Deductible
Medical Supplies *Including insulin pump and ostomy supplies*	20% Coinsurance after Deductible
Hearing Aid Devices *Adult and Child*	20% Coinsurance after Deductible
Vision Hardware	
Vision Hardware *Adult*	Up to $100 allowance towards purchase
Vision Hardware *Pediatric*	No Charge
Ambulance Services	
Emergency Ambulance Transport *Land and Air*	$250 Copayment per transport
Emergency and Urgent Care	
Emergency Room Services *Copayment waived if admitted inpatient within 24 hours*	$350 Copayment per visit after Deductible
Urgent Care	$80 Copayment per visit

Pharmacy Benefits	What You Pay
Prescription drugs, insulin, diabetic supplies, therapeutic vaccines, immunotherapy and chemotherapy prescribed by a practitioner. Diabetic supplies refer to, for example, alcohol swabs/wipes, lancets, lancet devices, insulin syringes and needles, glucose monitors/meters, glucose control solutions, and blood and urine glucose and ketone test strips.	
30-Day Supply *Dispensed through a participating retail pharmacy or administered in the outpatient setting or in your home.*	
Tier 0 Preventive Prescription Drugs	$0 Copayment per prescription or refill
Tier 1 Generic and Adherence Generic Prescription Drugs *Adherence Generics are limited to specific medications to treat certain conditions and are designated in the comprehensive drug list with the label "$0" and are available at no cost, subject to applicable deductible*	$15 Copayment per prescription or refill
Tier 2 Preferred Brand Prescription Drugs	$55 Copayment per prescription or refill
Tier 3 Non-Preferred Brand Prescription Drugs	50% Coinsurance per prescription or refill after Deductible
Tier 4 Preferred Specialty Prescription Drugs *Must be provided through a plan participating specialty pharmacy*	40% Coinsurance per prescription or refill after Deductible
Tier 5 Non-Preferred Specialty Prescription Drugs *Must be provided through a plan participating specialty pharmacy*	50% Coinsurance per prescription or refill after Deductible
90-Day Supply *Dispensed through a participating mail order pharmacy.*	
Tier 0 Preventive Drugs	$0 Copayment per prescription or refill
Tier 1 Generic and Adherence Generic Prescription Drugs *Adherence Generics are limited to specific medications to treat certain conditions and are designated in the comprehensive drug list with the label "$0" and are available at no cost, subject to applicable deductible*	$40 Copayment per prescription or refill
Tier 2 Preferred Brand Prescription Drugs	$150 Copayment per prescription or refill
Tier 3 Non-Preferred Brand Prescription Drugs	50% Coinsurance per prescription or refill after Deductible
Tier 4 Preferred Specialty Prescription Drugs	No mail order
Tier 5 Non-Preferred Specialty Prescription Drugs	No mail order

If the Practitioner indicates “Dispense as Written”, or if the member requests the brand name product for a prescription Drug when a Network Health approved generic is available, the member must pay the applicable Copayment or Coinsurance plus the Ancillary Fee. The Ancillary Fee is the cost difference between the brand name product and the generic product. When generic substitution conflicts with state regulations or restrictions, the pharmacist must gain approval from the prescribing practitioner or use the generic equivalent. ACA Preventive Drugs may be exempt from the Ancillary Fee when a generic version has been tried, the practitioner indicates the brand name product is medically necessary and prior approval for the $0 cost share has been approved. Ancillary Fees will apply toward your Deductible and/or Out-of-Pocket Limit. Upon reaching the Out-of-Pocket Limit all covered expenses will be paid at 100 percent.

When applicable, any monetary amount of the Prescription Drug Product covered by a Copay Assistance Card will not apply toward the Deductible and/or Out-of-Pocket Limit.

To receive a copy of the Network Health Plan Comprehensive Drug List, please call Member Experience at the number on the back of your ID card or visit networkhealth.com.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-275-1400 or visit https://www.networkhealth.com/__assets/pdf/individual-benefits-2026/individualpolicy.pdf. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-855-275-1400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 member / $3,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive services, office visits, tests and prescription drugs are covered before you meet your deductible. See the specific services listed below denoted 'Deductible does not apply'.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,300 member / $4,600 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, denied benefits, balance billing charges, the benefit reduction amount when prior authorization is not obtained.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.networkhealth.com or call Network Health Customer	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an Out-of-network provider, and you might receive a bill from

Important Questions	Answers	Why This Matters:
	Service at 1-855-275-1400 for a listing of participating providers.	a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit; deductible does not apply	Not Covered	First three visits covered at No Charge; combined with behavioral health, substance abuse and maternity office visits.
	Specialist visit	$65/visit; deductible does not apply	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	$25/visit for lab; deductible does not apply $50/visit for x-ray; deductible does not apply	Not Covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.networkhealth.com	Generic drugs Tier 1	$15/retail Rx or refill or $40/mail order Rx or refill ; deductible does not apply	Not Covered	Certain generics are available for a $0 Retail copayment or a $0 Mail Order copayment. Refer to your formulary. Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription)
	Preferred brand drugs Tier 2	$55/retail Rx or refill or $150/mail order Rx or	Not Covered	Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of-Network Provider (You will pay the most)	
		refill ; deductible does not apply		order prescription)
	Non-preferred brand drugs Tier 3	50% coinsurance retail Rx or refill or 50% coinsurance mail order Rx or refill	Not Covered	Covers up to a 30-day supply (retail prescription); 30-90 day supply (mail order prescription)
	Preferred Specialty drugs Tier 4	40% coinsurance retail Rx or refill at specialty pharmacy	Not Covered	Covers up to a 30-day supply (specialty pharmacy); No mail order
	Non-Preferred Specialty drugs Tier 5	50% coinsurance retail Rx or refill at specialty pharmacy	Not Covered	Covers up to a 30-day supply (specialty pharmacy); No mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	$65/visit; deductible does not apply	Not Covered	None
If you need immediate medical attention	Emergency room care	$350/visit	$350/visit	Copayment waived if admitted inpatient within 24 hours
	Emergency medical transportation	$250/transport; deductible does not apply	$250/transport; deductible does not apply	None
	Urgent care	$80/visit; deductible does not apply	$80/visit; deductible does not apply	Services provided by an Out-of-network facility are covered only when received outside the service area. Services received at an Out-of-network non-Hospital-based Urgent Care Facility require that Network Health be notified within one business day.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Preauthorization is required.
	Physician/surgeon fees	$65/visit; deductible	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of-Network Provider (You will pay the most)	
		does not apply		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit; deductible does not apply	Not Covered	
	Inpatient services	20% coinsurance	Not Covered	Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance	Not Covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	$65/visit; deductible does not apply	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance	Not Covered	Preauthorization is required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Limited to 60 visits per benefit year. Preauthorization is required.
	Rehabilitation services	20% coinsurance	Not Covered	Limited to 20 visits each per benefit year for Physical, Occupational, Speech and Pulmonary Therapy. Cardiac Rehab is limited to 36 visits per benefit year. Preauthorization is required.
	Habilitation services	20% coinsurance	Not Covered	Limited to 20 visits each per benefit year for Physical, Occupation and Speech Therapy
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 30 days per benefit year. Preauthorization is required.
	Durable medical equipment	20% coinsurance	Not Covered	Limited to 20 DME devices/items per year, whether rented or purchased as indicated in the Policy. Preauthorization is required.
	Hospice services	No Charge	Not Covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one Routine Eye Exam per 12 month period.
	Children's glasses	No Charge	Not Covered	None
	Children's dental check-up	No Charge	Not Covered	No Charge via 100% reimbursement for 2

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of-Network Provider (You will pay the most)	
				exams, 2 cleanings and one bitewing x-ray per 12 month period

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Oral Surgery
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Department of Health and Human Services Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, or you may contact Network Health Member Experience Team at 1-855-275-1400 for more information. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or you may contact Network Health Member Experience Team at 1-855-275-1400 for more information.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.02** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copayment	$65
Hospital (facility) coinsurance	20%
Other copayment	$25

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,360**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$65
Hospital (facility) coinsurance	20%
Other copayment	$25

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter))*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

The plan's overall deductible	$1,500
Specialist copayment	$65
Hospital (facility) copayment	$350
Other copayment	$25

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$700
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Network Health Plan

Individual Health Maintenance Organization (HMO) Medical Policy

2026 QHP Policy
HMO Plans underwritten by Network Health Plan

Network Health Plan (NHP) has issued this Policy to You to provide You with a health benefit plan.

CONTACTING NETWORK HEALTH

To contact the Network Health Member Experience Team, call the telephone number listed on the back of Your ID card. If You prefer, You may send a secure message through the Member portal at login.networkhealth.com.

COVERED SERVICES BASED ON PLAN TYPE

This Policy is a Health Maintenance Organization (HMO) plan. A Participating Provider must provide covered Services. Except as specifically stated in this document, services received from a Non-Participating Provider are not covered. Participating Providers have agreed to accept discounted payment for Covered Services with no additional billing to the covered person other than Copayment, Coinsurance and Deductible amounts.

You are responsible for all expenses related to non-Covered Services, even if deemed Medically Necessary.

All Providers are independent contractors. NHP has no legal liability resulting from the treatment or lack of treatment rendered to You.

INFORMATION ABOUT DEFINED TERMS

Because this is a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in ARTICLE XIII ~ DEFINED TERMS.

When We use the words “We,” “Us” and “Our” in this document, We are referring to Network Health Plan or a delegated entity. When We use the words “You” and “Your,” We are referring to people who are Members, as that term is defined in ARTICLE XIII ~ DEFINED TERMS.

PEDIATRIC DENTAL DISCLOSURE

This Policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact Your agent or the Health Insurance Marketplace if You wish to purchase pediatric dental coverage or a stand-alone dental services product.

POLICY EFFECTIVE DATES AND CHANGES

The insurance contract includes this Policy, Your application, and any applicable Riders and/or Amendments. This Policy describes in detail the eligibility, Effective Date of coverage, continuation of coverage and termination rules.

In addition to this contract, NHP provides a Summary of Benefits and Coverage as an easy-to-read summary of your Benefits.

NHP may modify this Policy by attaching legal documents called Riders and/or Amendments that will change certain provisions. If there is a conflict between this Policy and any summaries provided to You, this Policy will control.

This Policy replaces any previous Policy You may have been issues.

This Policy will take effect on the Effective Date specified in ARTICLE II~ EFFECTIVE DATE OF COVERAGE of this Policy. Coverage under this Policy will begin at 12:01 a.m. and end at midnight in the Central Time Zone. This Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to termination of this Policy.

In addition to this contract, NHP provides a Summary of Benefits and Coverage as an easy-to-read summary of your Benefits.

RENEWABILITY
This Policy remains in effect at the option of the Policyholder, except as provided in ARTICLE IX ~ TERMINATION OF COVERAGE.

This is Your Policy as long as You are eligible for insurance and remain insured. This document contains the terms and conditions of Your insurance coverage.

RIGHT TO RETURN POLICY
You may return this Policy within ten calendar Days after receipt. If You do so, this Policy is void from the beginning and all Premiums paid will be refunded. You have an unrestricted right to return this Policy within ten calendar Days after receipt to NHP or to the agent through whom this Policy was purchased.

STATEMENTS MADE IN YOUR APPLICATION
Please review Your application write to Us within ten days if any information shown on the application is not correct and complete. Omissions or misstatements in the application could cause an otherwise valid Claim to be denied. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

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MEMBER RIGHTS AND RESPONSIBILITIES

ARTICLE I - MEMBER RIGHTS AND RESPONSIBILITIES

As a Member with Network Health Plan (NHP) You have certain rights and responsibilities. NHP is committed to providing You with services that respect Your rights. This document and other materials contain important information regarding Your Benefits, rights and responsibilities, which include, but are not limited to, the following.

MEMBER RIGHTS

1) You have the right to receive information about NHP, its services, Practitioners and Providers.
2) You have the right to be treated with respect and recognition of Your dignity and right to privacy.
3) You have the right to participate with Practitioners in decision making regarding Your health care.
4) You have the right to discuss appropriate or Medically Necessary treatment options for Your condition(s), regardless of cost or Benefit coverage.
5) You have a right to voice Complaints or Appeals about NHP, the care received and/or the privacy of protected health information.
6) You have the right to select or change a Primary Care Practitioner for any reason.
7) You have the right to review Your medical records with Your Primary Care Practitioner.
8) You have the right to receive prompt and courteous service from representatives regarding Benefits, eligibility, Claims or other NHP matters.
9) You have the right to be informed of Your Diagnosis, treatment and prognosis from Providers in terms You understand.
10) You have the right to refuse treatment and to know of the probable consequences of that action.
11) You have the right to make recommendations regarding Our Members' rights and responsibilities.

MEMBER RESPONSIBILITIES

1) You have the responsibility to pay Premiums according to Your monthly Premium invoice in order to maintain your NHP coverage and pay your share of the cost for medical services.
2) You are responsible for communicating openly with health care Provider(s) or health plan personnel. If You have questions about Your treatment plan it is Your responsibility to discuss Your concerns and understand any explanation and instructions.
3) You are responsible for reading and understanding Your Benefits.
4) You are responsible for following the policies and procedures that NHP establishes.
5) You are responsible for following the plans and instructions for care that You and Your health care Provider(s) have agreed to.
6) You are responsible for treating all health care Provider(s) and health plan personnel with respect and courtesy.
7) You are responsible for providing information that NHP and Your health care Provider(s) need to take care of You.
8) You are responsible for notifying Your health care Provider(s) and NHP of changes in insurance coverage, eligibility, address or phone number.
9) You are responsible for keeping scheduled appointments or give proper notice of delay or cancellation.

10) You are responsible for expressing Your concerns or dissatisfaction with NHP or Your health care Provider(s) so that We can fix the situation.
11) You are responsible for understanding Your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
12) You are responsible for confirming which health care Provider(s) are In-Network prior to accessing services. Our Find a Doctor tool on our website is the most up-to-date source for this information.
13) You are responsible for obtaining a Prior Authorization from Network Health Utilization Management for any non-emergent services You wish to obtain from Non-Participating health care Provider(s). This includes when a Participating Practitioner has referred you to Non-Participating health care Provider(s).
14) You are responsible to verify that Prior Authorization is obtained when receiving services that require Prior Authorization.

EFFECTIVE DATE OF COVERAGE

ARTICLE II ~ EFFECTIVE DATE OF COVERAGE

ELIGIBILITY

You may enroll for coverage by filing a Written Request for coverage on forms approved by NHP and paying any required Premium during an enrollment period, described below. This Policy will not cover You until Your Effective Date and We receive Your first month's Premium. If You purchased Your Policy through the Health Insurance Marketplace You must contact them directly at 800-318-2596 or log in to your account on **healthcare.gov** to make any changes (e.g., address changes, adding dependents, terminations).

NHP is not responsible for Claims We pay when You or Your Dependents are not eligible for coverage. If We pay Claims and later learn You or Your Dependent(s) were not eligible for coverage, You will be responsible to reimburse NHP or Your Provider. You will also be responsible for attorney's fees and expenses We incur in recovering Our payments.

Policyholder Eligibility

You will become eligible for this Policy if You:

a) Submit an application for coverage through NHP or the Health Insurance Marketplace;
b) Are a Wisconsin resident and reside in the NHP Service Area ;
c) Meet the requirements for being eligible for coverage under a Qualified Health Plan, including (but not limited to) each of the following:
    i. You are a citizen or national of the United States or a non-citizen who is lawfully present in the United States.
    ii. You reasonably expect to be a citizen or national of the United States or a non-citizen who is lawfully present in the United States for the entire period for which enrollment is sought.
    iii. You are not incarcerated (other than incarceration pending disposition of charges).

Dependent Eligibility

Your Dependent(s), as defined in ARTICLE XIII ~ DEFINED TERMS, is eligible for coverage under this Policy if:

a) You submit an application for coverage through NHP or the Health Insurance Marketplace that names the Dependent(s).
b) The Dependent meets the requirements for being a Policyholder listed in subsection c) paragraphs i), ii) and iii) of "Policyholder Eligibility" above.

EFFECTIVE DATE OF COVERAGE

Annual Open Enrollment Period

Annual open enrollment period, as determined by the Centers for Medicare and Medicaid Services (CMS), is the timeframe when You may enroll Yourself and Dependents. The annual open enrollment period starts November 1 and runs through December 15. If You select coverage during the annual open enrollment period on or before December 15, the Effective Date of coverage will be January 1 of the following year.

Special Enrollment Periods (SEP)

EFFECTIVE DATE OF COVERAGE

You may enroll, or change coverage for, Yourself or a Dependent(s) during a 60-Day SEP. If Your Policy was purchased through the Health Insurance Marketplace, You must contact them directly to make changes. If the Policy was purchased through NHP, You must submit an application for coverage through NHP. You will be required to pay any Premiums due during that period. All SEPs will require proper documentation. You (or Your Dependent's) Effective Date of coverage will be:

a) If the SEP is for birth, adoption or placement for adoption, the Effective Date of coverage will be the date of birth, adoption or placement for adoption.
    i. In the case of a newborn child, including the newborn of a qualified Dependent child, if You do not enroll the newborn child within 31 Days of birth, You may still enroll the child on or before their first birthday. To do so You must submit an application for coverage through NHP or the Health Insurance Marketplace. You will be required to pay the additional Premium.
b) If the SEP is for marriage or loss of minimum essential coverage, the Effective Date of coverage will be the first day of the month following the application submission.
c) If the SEP is for any other reason, the Effective Date of coverage will be as follows:

Date You Select Your Plan	Effective Date
1st – 15th of the month	First day of the following month*
16th – last day of the month	First day of the second following month*

For example, if You select coverage on May 10, Your Effective Date will be June 1.

If You select coverage on May 20, Your Effective Date will be July 1.

*Policies purchased through the Health Insurance Marketplace may designate an earlier Effective Date of coverage in limited circumstances.

A Policyholder must have active coverage for a Dependent's coverage to become effective.

ARTICLE III –PREMIUM

PAYMENT OF PREMIUM

Premiums are payable to NHP. No insurance agent, insurance broker or insurance consultant is authorized to accept any Premium payment on behalf of NHP. The Policyholder must timely pay the monthly Premium in order to maintain this Policy. Premium payments are due the last day of the month prior to the first day of the month of coverage. For example, the Premium for May is due on April 30.

The payment of any Premium will not keep this Policy in force beyond the due date of the next Premium, except as provided under the Grace Period below. If full Premium is not received by NHP before or at the end of the Grace Period, this Policy will terminate and coverage for the Policyholder and Dependents will end either at the end of the period for which the last full Premium payment has been paid or, if You are receiving Advance Premium Tax Credit (APTC), at the end of the first month of the three-month grace period.

You must pay the first month's Premium to complete the enrollment process. If You apply for coverage and select a plan, but then You fail to pay the first month's Premium, You will not be enrolled.

NHP will not accept third-party payments for Premiums, except from the following:

a) A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
b) An Indian tribe, tribal organization or urban Indian organization.
c) A local, state or federal government program, including a grantee directed by a government program to make payments on its behalf.

GRACE PERIOD

After payment of the first month's Premium, if You fail to pay Your Premium by the assigned due date, You have a grace period before Your coverage can be terminated. The grace period is different if You are receiving an APTC or if You are not. If You are receiving an APTC You have a grace period of three consecutive months. If You are not receiving an APTC You have a grace period of 31 Days.

We will pay for medical care and covered prescription drugs received during the first month of the grace period if You are receiving an APTC. However, for the second and third months of the grace period, We will withhold (or "pend") payment for medical Claims until You pay all outstanding Premiums. Pharmacy Claims will process at point of sale, but your cost share will be 100 percent. If full Premium is not received, this Policy will end the last day of the first month of the grace period. If Your coverage is terminated for failure to make all payments in full, You will be responsible for paying any medical expenses incurred during the second and third months of the grace period. Once Your plan has been terminated, You will not be able to re-enroll in a Health Insurance Marketplace Qualified Health Plan (QHP) until the next open enrollment period, unless You qualify for a special enrollment period (SEP) in the interim. Loss of coverage for failure to pay Premiums does not trigger a SEP.

PREMIUM

If You are not receiving APTC and have paid the first month's Premium, NHP will allow a grace period of 31 Days following a Premium due date to pay subsequent monthly Premiums. During this grace period, this Policy will remain in force. No Benefits are payable for expenses incurred during the grace period if the Premium has not been received by the end of the grace period. If the Policyholder fails to pay the Premium during the grace period, this Policy will automatically end at the end of the period for which the last full Premium payment has been paid.

The grace period does not apply if this Policy terminates for reasons other than nonpayment of Premium.

PREMIUM CHANGES

NHP reserves the right to change Premiums under this Policy on any Premium due date by giving the Policyholder at least 31 Days prior written notice. If Premiums increase 25 percent or more, NHP will notify the Policyholder of such change 60 Days before the Effective Date.

ARTICLE IV –OBTAINING HEALTH SERVICES

This section provides important information for You to know when accessing health care services.

PRIMARY CARE PRACTITIONER (PCP)

As a managed care plan, NHP strongly recommends You select a Primary Care Practitioner (PCP) and maintain a relationship with them.

A PCP directs and coordinates Your health care. The PCP provides routine care, coordinates needed specialty care and assists You in obtaining Authorizations from NHP. We recommend You use a Participating Practitioner to manage Your health care services.

Selecting a PCP is very important because We will communicate with Your PCP to help coordinate Your care. To select Your own PCP, You may contact Our Member Experience Team by calling the number on the back of Your ID card or log in to Your Network Health account at **login.networkhealth.com**. If You haven't or don't choose a PCP, We will rely on Claims data to assign You a PCP. This is done based on PCPs You've seen the most who are In-Network and accepting new patients. If You haven't seen a PCP in two years, We will work with Our Provider partners to assign You a PCP who is in Your area and accepting new patients. Whether Your PCP is selected or assigned, You'll receive the same high-quality care.

PRIOR AUTHORIZATION AND PRE-ADMISSION REVIEW

We provide coverage for Medically Necessary Emergency Health Services and Urgent Care services. For certain services, including non-Emergent and non-Urgent services from a Non-Participating Provider, You are required to obtain Prior Authorization (approval) from NHP before receiving the services or they may not be covered. In some situations, such as following receiving Emergency services from a Non-Participating Practitioner and/or Non-Participating Provider, this authorization may be obtained within 48 hours or the next business day of regaining capability or when medically feasible.

NHP, directly or through a vendor, reviews certain services and treatment plans to ensure they are Medically Necessary and appropriate. If You are receiving services from a Participating Provider, they will obtain Prior Authorization or pre-admission review to receive coverage for these services. However, if You are being treated by a Non-Participating Provider, You are responsible to verify that Prior Authorization is obtained when receiving services that require Prior Authorization.

Examples of health services requiring Prior Authorization include the following.

a) Entering a Hospital as a scheduled (non-Emergent) Inpatient
b) Obtaining non-Emergent, non-Urgent services from a Non-Participating Practitioner or Provider
c) Certain services received from a Specialty Care Practitioner (SCP), such as medical oncology, radiation therapy and genetic laboratory testing

For a list of services requiring Prior Authorization, log in to Your Network Health account at **login.networkhealth.com** and click on **My Materials** to find a link to Your **Services Requiring**

Prior Authorization list. Please refer to this website often, as We have full discretionary authority to change it without notice to You. It is Your responsibility to obtain NHP's Prior Authorization, when required, before receiving health care services from Non-Participating Providers.

For non-Emergent services with Non-Participating Providers, You must notify NHP prior to receiving the service. You and Your treating Provider will receive written notification from NHP either approving or denying services with Non-Participating Providers. If you do not receive approval from NHP, You will be held financially responsible for the cost of those services.

NHP's Prior Authorization does not mean NHP will cover a health service or item. All other provisions, including the Exclusions and Limitations and applicable Rider(s) and/or Amendments, will also affect whether NHP covers a health service or item. NHP cannot review or Prior Authorize coverage outside the current Benefit Year.

Your Practitioner or an authorized Provider must contact NHP's Utilization Management Department to obtain Prior Authorization. NHP's Utilization Management Department will review the Practitioner's request at least two business days prior to the requested service. NHP will determine whether the service is Medically Necessary and appropriate.

NON-PARTICIPATING PROVIDER COVERAGE

Except for Emergency Health Services, if You wish to receive coverage for services from a Non-Participating Provider, You must obtain Prior Authorization from NHP as described above. A Maximum Out-of-Network Allowable Fee will be applied when services are received from a Non-Participating Provider. If You choose to receive non-Emergency Health Services from a Non-Participating Provider, **You will be responsible for the cost of the Non-Participating Provider's charge for such services**. **Because NHP does not have an agreement with Non-Participating Providers and there is no limit on what a Non-Participating Provider may charge, this cost may be significant**. In addition, when Providers are Non-Participating, NHP is unable to oversee the services they provide which limits our ability to ensure You receive quality care. To confirm Your Provider is a Participating Provider, please call the Member Experience phone number on the back of Your ID card or visit **networkhealth.com**, select **Find a Doctor** and click on Start Your Search. Enter location information and then under Choose a plan select **Individual and Family (I buy insurance on my own.)**

If You or Your Dependent get Emergency Services from a Non-Participating Provider, the most the Provider or facility may bill You is Your Plan's In-Network cost sharing amount (such as Copayments and Coinsurance) as indicated on Your Summary of Member Responsibility Table. You can't be Balance Billed for these Emergency Services.

If You are admitted to a Non-Participating facility following Emergency Health Services, You must notify Us by calling the Member Experience number on the back for Your ID Card within 48 hours or the next business day of Your admission or of receiving the services or

when medically feasible to provide notice. If You are physically or mentally incapable of providing notice within that time, You must provide notice within 48 hours or the next business day of regaining capability or when medically feasible. A minor's parent or guardian must provide notice to Us withing 48 hours or the next business day of the minor's admission to a Non-Participating facility following Emergency Health Services. If the parent or guardian is not aware of the minor's admission, the parent or guardian must notify NHP within 48 hours or the next business day of becoming aware of the admission. Once notification is made, Network Health will determine if inpatient level of care is Medically Necessary.

As part of the review of the admission, when You are medically stable, NHP's Utilization Management Department may arrange for Your mandatory transfer to a Participating Provider. Failure to agree to transfer may result in You being financially responsible for that portion of the charges of the Non-Participating Facility attributable to the delay.

In receiving services from a Participating Provider, a Non-Participating Provider may be utilized without Your knowledge. This sometimes occurs for certain services such as laboratory, radiology, pathology or other ancillary services. In this situation, the Non-Participating Provider charges will be paid as Participating Provider charges.

Reimbursement to a Non-Participating Provider will not exceed the Maximum Allowable Out-of-Network Fee. This Fee is determined by Us, using a variety of resources, based on the following:

a) When covered health care services are received from a Non-Participating Provider, the Maximum Allowable Fee is based on the lesser of:
    i. The amount billed by the Non-Participating Provider; or
    ii. An amount
        1. Negotiated with the Non-Participating Provider on an individual case basis; or
        2. Based on amounts charged by health care Providers for similar health care services in a geographical area; or
        3. Directly specified for a particular service or supply; or
        4. That will not exceed the contracted rate established with a vendor or, in the case of pharmacy Claims, the contracted rate with the Pharmacy Benefit Manager (PBM) established between NHP and the PBM.
b) We annually update Maximum Out-of-Network Allowable Fees when updated data from CMS becomes available. Amounts used are the rates established by CMS on January 1 of the current year. Updates to the Maximum Out-of-Network Allowable Fees are typically implemented within 30 to 90 Days after CMS updates its data.
c) There may be times when You receive Participating Provider Benefits from a Non-Participating Provider, such as in an Emergency situation. If a negotiated rate is not available, We will seek to reimburse the Non-Participating Provider using the Maximum Out-of-Network Allowable Fee.
d) There may be times when We direct payment of the Maximum Out-of-Network Allowable Fee to You instead of the Non-Participating Provider. In those cases, You are responsible for payment to the Non-Participating Provider for services You receive, as well as any additional amounts charged by such Non-Participating Provider.

DISCHARGE PLANNING

NHP is available to work with You and Your Providers to plan needed care and a smooth transition when leaving a Hospital or other health care facility. Our care management staff may contact You to help with Your discharge plan. You may also contact NHP for assistance by calling the number on the back of Your ID card.

SECOND OPINION

You may obtain a second opinion from a Participating Practitioner to make clear, review or confirm a Diagnosis or treatment plan. You or Your Practitioner may request a second opinion. The Practitioner who provides the second opinion cannot furnish care or perform any procedure at the time of the evaluation.

CARE MANAGEMENT

NHP offers care management services for covered persons with multiple chronic, medically complex, catastrophic or terminal conditions. The goal of care management is to ensure care is well coordinated, to enhance the Your quality of life and to promote the most cost-effective use of Benefits. This program does the following:

a) Informs You and Your Practitioners of Benefits;
b) Identifies appropriate treatment options;
c) Arranges and coordinates Provider and community services, including but not limited to, Home Care, Palliative Care and Hospice services.

DENIALS OF AUTHORIZATIONS OR CONTINUED STAY REQUESTS

NHP's Utilization Management Department will apply medical review criteria to a:

a) Procedure;
b) Continued length of stay;
c) Treatment plan;
d) Health service;
e) Health item;
f) Site of care.

We will deny any request for Authorization for services or continued stay that does not meet Our medical review criteria or the terms of this Policy. We will provide written notice of a denial to You, Your Practitioner(s) and/or Your Provider(s). The written denial notice will include:

a) A statement that the requested health service does not meet Our criteria for Medically Necessary or appropriate care;
b) The Medical Necessity guideline provision that served as the basis for the denial;
c) An explanation of Your Grievance resolution process.

EMERGENCY AND URGENT CARE SERVICES RECEIVED OUTSIDE THE UNITED STATES

If You receive Emergency Health Services or Urgent Care services outside the United States You are responsible for ensuring that the Provider is paid. If the Provider will not bill NHP directly with the Claim in English, then You will need to pay the Claim up front and then submit the Claim in English along with proof of payment to NHP for reimbursement. NHP will reimburse You for any Covered Services in U.S. currency, based on the U.S. equivalency rate that is in effect on the date You paid the Claim or on the date of service if paid date is not known.

ARTICLE V ~ BENEFIT PROVISIONS

SCHEDULE OF BENEFITS

NHP will cover Benefits set forth in this Article and any applicable Riders and/or Amendments. Benefits are subject to cost sharing (Copayment, Coinsurance, Deductible) as specified in the Summary of Member Responsibility Table (SOMR). For a list of Benefits requiring Prior Authorization, log in to Your Network Health account at **login.networkhealth.com** and click on **My Materials** to find a link to **Your Services Requiring Prior Authorization list**. Please refer to this website often, as it may change occasionally without notice to You.

AMBULANCE SERVICES

Emergency Transportation

NHP will cover ground or air ambulance transport for Emergency conditions by a licensed ambulance service. We will pay for transport to the nearest facility that can furnish Emergency Health Services. NHP will cover non-Emergency transfer ambulance service that We initiate without cost sharing. NHP will also cover Emergency Services provided by an ambulance service to You even if the unit does not provide transportation.

Non-Emergency Transportation

a) **Transportation From Non-Participating Hospital to Participating Hospital once Member is stabilized (non-Emergency)** – If You are admitted to a Non-Participating Hospital immediately after Emergency Services are received, NHP will cover non-Emergency air or ground ambulance services to transport You from the Non-Participating Hospital to the closest Participating Hospital that can provide the needed treatment once the Your condition has been stabilized as certified by the Your Practitioner. If notified as required, We may communicate with the facility to initiate the transfer, including Authorization of such transport.

b) **Facility-to-Facility Transfers (non-Emergency)** – NHP will cover air or ground ambulance services only to transport You to or from a facility or between facilities for required treatment that is not available at the initial facility when the Practitioner certifies such transportation as Medically Necessary and the Plan Prior Authorizes the service. Such transportation is covered only from the initial facility to the nearest Participating facility qualified to render the special treatment when there is a receiving Participating facility within a reasonable distance from the initial facility. If not within a reasonable distance, as determined by NHP, We will cover transportation from the initial facility to the nearest Nonparticipating facility.

If You are admitted to a Non-Participating Hospital following an Emergency department visit, as part of the review of the admission, NHP's Utilization Management Department in collaboration with the Practitioner will determine if You are medically stable, and if so, may arrange for Your mandatory transfer to a Participating Provider. Failure to agree to transfer to a Participating Hospital as required above will result in You being financially responsible for that portion of the charges of the Non-Participating Facility after the date transfer was supposed to occur. You may be responsible for all charges after that date.

BENEFIT PROVISIONS

AUTISM SERVICES

NHP will cover the treatment for the primary, verified Diagnosis of autism spectrum disorder if the treatment is evidence-based and prescribed and rendered by a Practitioner who is qualified to provide intensive-level or non-intensive-level services. NHP may require a second opinion of the Diagnosis triggering the autism treatment.

Prescription medications and Durable Medical Equipment (DME) will not count toward the coverage limits noted below.

a) **Intensive-Level Services**
NHP will provide coverage for evidence-based behavioral intensive-level services per covered person per year, with the covered person receiving at least 20 hours of therapy per week over a continuous six-month period of time for up to 48 months. The 48 months of intensive-level treatment will be treated as a cumulative amount. For example, a child who received 24 months of intensive-level treatment under another insurer or the Medicaid waiver program would be entitled to another 24 months of treatment under NHP. The intensive-level services must begin after the covered person is two (2) years of age and before the Member is nine years of age.

b) **Non-Intensive Level Services**
NHP will provide coverage for evidence-based behavioral non-intensive-level services for a covered person not receiving intensive-level services. Non-intensive-level services must sustain and maximize gains made during intensive-level treatment or improve the condition.

BREAST RECONSTRUCTION

NHP will cover breast reconstruction related to a covered mastectomy. We will pay for:

a) Reconstruction of the breast on which the mastectomy was performed.
b) Surgery and reconstruction of the other breast to produce an even appearance.
c) Prosthesis and treatment of physical complications at all stages of the mastectomy.

CANCER CLINICAL TRIAL

NHP will cover Routine Patient Care to the extent required by Wisconsin Statute 632.87(6). Coverage of Routine Patient Care during the course of treatment in a cancer clinical trial is limited to cancer clinical trials meeting all the following criteria:

a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
b) The treatment provided as a part of the trial is given with the intention of improving the trial participant's health outcomes.
c) The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathology.
d) The trial does one of the following:
    i. Tests how to administer a health care service, item or drug for the treatment of cancer;
    ii. Tests responses to a health care service, item or drug for the treatment of cancer;
    iii. Compares the effectiveness of health care services, items or drugs for the treatment of cancer;

iv. Studies new uses of health care services, items or drugs for the treatment of cancer.

e) The trial is approved by one of the following:
   i. National Institute of Health, or one of its cooperative groups or centers, under the Federal Department of Health and Human Services;
   ii. Food and Drug Administration (FDA);
   iii. Federal Department of Defense;
   iv. Federal Department of Veteran Affairs.

CARDIAC REHABILITATION SERVICES
NHP will cover Stage 1 (Inpatient) and Stage 2 (Outpatient Monitored) cardiac Rehabilitation Services. This Benefit is limited to 36 visits per Benefit Year.

CHEMOTHERAPY
NHP will cover chemotherapy administered orally, intravenously or by injection. Oral chemotherapy will not require a higher Copayment, Deductible or Coinsurance than is required for injected or intravenous chemotherapy.

CHIROPRACTIC CARE
NHP will cover spinal adjustment and manipulation, x-rays for manipulation and adjustment, and other modalities performed by a Provider.

COLORECTAL CANCER SCREENING
NHP will cover colorectal cancer screening without cost sharing following the United States Preventive Services Task Force (USPSTF) guidelines. Cost sharing will apply for covered persons outside of the recommended age range and/or for services beyond the USPSTF guidelines.

Please refer to Your Preventive Services Guide for a listing of covered preventive colorectal cancer screening services.

CONTRACEPTIVE COVERAGE
Benefits for contraceptive coverage and family planning include the following.

a) Voluntary sterilization procedures such as tubal ligations and vasectomies.
b) Food and Drug Administration approved contraceptives, including over-the-counter (OTC) products, self-administered contraceptive medications and devices when listed in the Comprehensive Drug List and purchased from a Participating pharmacy with a valid prescription are covered at no cost. If the Practitioner indicates “Dispense as Written,” or if the Member requests the brand name product for a prescription Drug when a Network Health approved generic is available, the Member must pay the applicable Copayment or Coinsurance plus the Ancillary Fee. The Ancillary Fee is the cost difference between the brand name product and the generic product. When generic substitution conflicts with state regulations or restrictions, the pharmacist must gain approval from the prescribing Practitioner or use the generic equivalent. Affordable Care Act (ACA) Preventive Drugs may be exempt from the Ancillary Fee when a generic version has been tried, the

Practitioner indicates the brand name product is Medically Necessary and Prior Authorized for the $0 cost share has been approved.

c) The administration of approved female contraceptives in the Practitioner's office. The administration, insertion and removal of approved contraceptive devices, such as an intrauterine device (IUD) is covered at no cost.

Covered contraceptive services will be provided at no cost only if provided by a Participating Provider. Vasectomies will be subject to cost share.

DENTAL CARE FOR ACCIDENTS

NHP will cover dental care for services related to the repair or replacement of sound and natural teeth. We will only pay for teeth damaged as the result of a covered bodily Injury that occurs while You are covered by NHP. We only cover services provided during the 12 month period following the date of Injury. Your dentist may furnish the initial evaluation related to an Accidental Injury. Any services following the initial evaluation must be provided by a Participating Provider.

NHP defines a tooth as sound and natural if, prior to the Accidental Injury, ALL the following criteria are met:

a) There is no evidence of periodontal (gum) disease;
b) The tooth is fully restored and decay free;
c) The tooth is fully functional.

Dental services for accidents are covered when all the following are true:

a) Treatment is necessary because of Accidental Injury.
b) Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
c) The dental Injury is severe enough that initial contact with a Practitioner or dentist occurred within 72 hours of the Accident. (You may request an extension of this time period provided you do so within 60 Days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Dental services to repair damage caused by Accidental Injury must be started and completed within 12 months of the Accident.

Benefits for treatment of accidental Injury are limited to the following.

a) Emergency examination
b) Endodontic (root canal) treatment
c) Extractions
d) Necessary diagnostic x-rays
e) Post-traumatic crowns, if such are the only clinically acceptable treatment
f) Pre-fabricated post and core
g) Replacement of lost teeth due to the Injury by implant, dentures or bridges
h) Simple minimal restorative procedures (fillings)
i) Temporary splinting of teeth

DENTAL CARE – HOSPITAL OR AMBULATORY SURGICAL CENTER

NHP will cover Hospital or Ambulatory Surgical Center services, including anesthetics, for dental care provided in the facility, if any of the following applies.

a) The Member is a child under the age of five.
b) The Member has a chronic disability as defined by applicable state law.
c) The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

DIABETES TREATMENT, EQUIPMENT AND SUPPLIES

NHP covers diabetic equipment and supplies under;

a) The medical benefit when provided by Practitioners or Providers.
   Coverage includes the following:
   i. Equipment, such as glucometers
   ii. Continuous glucose monitors and supplies- for insulin dependent diabetics
   iii. The installation and use of insulin infusion pumps (for additional information see Durable Medical Equipment (DME) and Disposable Medical Supplies below)
   iv. Batteries to operate such equipment
   v. Supplies, including insulin, syringes, test strips, alcohol and lancets
   vi. Medical eye examinations (dilated retinal examinations)
b) The prescription drug Benefit when purchased at an In-Network pharmacy.
   Coverage includes the following.
   i. Equipment, such as glucometers
   ii. Continuous glucose monitors and supplies- for insulin dependent diabetics
   iii. Supplies, including insulin, syringes, test strips, alcohol and lancets

Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Practitioner and provided by appropriately licensed or registered health care professionals.

Certain laboratory tests for condition management of chronic diseases may be covered at a lower cost share. If applicable, this is outlined in your SOMR and includes the following tests.

a) Hemoglobin A1C, urine microalbumin to creatinine ratio, basic metabolic panel;
b) Fasting lipid panel for diabetes mellitus type 1 or 2, Coronary artery disease, Cerebrovascular disease, hyperlipidemia/dyslipidemia/hypertriglyceridemia;
c) Basic metabolic panel for hypertension.

DURABLE MEDICAL EQUIPMENT (DME) AND DISPOSABLE MEDICAL SUPPLIES

NHP will cover certain DME and disposable medical supplies. DME coverage is limited to 20 devices/items per year, whether rented or purchased, in accordance with the requirements set out in this document. We will cover these only when ordered by a Practitioner and purchased from an In-Network Provider. NHP will only cover DME rental costs up to the purchase price.

We will only cover DME that meets all the following criteria:

a) Able to withstand repeated use;
b) Ordered by a Practitioner for outpatient use primarily in a home setting;

c) Primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
d) Generally not useful in the absence of a bodily Injury or Illness;
e) Appropriate for home use;
f) Appropriate for treatment of Your bodily Injury or Illness;
g) Provided in the most cost-effective manner required by Your condition, including, at Our discretion, rental or purchase.

If more than one piece of Durable Medical Equipment can meet Your functional needs, Benefits are available only for the equipment that meets the minimum specifications for Your needs.

Our coverage includes, but is not limited to, the following types of DME.

a) Apnea monitors;
b) Bone growth stimulator;
c) Burn garments;
d) Crutches and wheelchairs;
e) Electronic breast pumps – basic model only generally will apply to preventive Benefit;
f) External cochlear devices and systems. Benefits for cochlear implantation are provided under the Hearing Devices section, as required by Wisconsin insurance law;
g) Home uterine monitors;
h) Insulin pumps and all related necessary supplies as described under the Diabetes Treatment, Equipment and Supplies section. Insulin infusion pumps are limited to one pump in a calendar year, and You must use the pump for 30 Days before purchase.
i) Lift mechanism only for chair lift;
j) Lymphedema (compression) stockings – limited to two pair per Benefit Year;
k) Mastectomy bras;
l) Mechanical equipment necessary for the treatment of chronic or acute respiratory failure;
m) Oxygen and oxygen-related supplies and equipment;
n) Orthotic devices, including but not limited to:
    i. Back braces;
    ii. Custom made ankle and foot orthosis;
    iii. Thoracic lumbar orthosis;
o) Standard Hospital-type bed;

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to an Illness or Accident/Injury.

Benefits under this section do not include any device, appliance, pump (other than an insulin pump), machine, stimulator or monitor that is fully implanted into the body.

Other than insulin infusion pumps noted above, NHP will cover DME repairs and replacement based on the average life of the product, as determined by NHP.

EMERGENCY HEALTH SERVICES

NHP will cover Emergency Health Services with Participating and Non-Participating Providers if rendered in an Emergency room. Benefits under this section include the facility charge,

supplies and all professional services required to stabilize Your condition and/or initiate treatment.

NHP will not pay for care provided outside its Service Area for Your convenience. This includes, for example, non-Emergency, non-Urgent Care for Members who live outside the Service Area. Reference the Urgent Care Services provisions within this document for Benefits.

GYNECOLOGICAL CARE
NHP will cover gynecological services without a referral, including annual exams.

HABILITATIVE SERVICES
NHP will cover Habilitative Services (those that help to acquire, maintain or improve skills necessary for daily functioning), medical supplies and DME.

NHP will cover outpatient therapy visits for each of the following categories per Benefit Year;

a) Occupational therapy –20 visits
b) Speech therapy –20 visits
c) Physical therapy –20 visits

HEARING DEVICES
NHP covers the cost of diagnoses, procedures, surgery and therapy related to cochlear implants or hearing aids for covered persons who are certified as deaf or hearing impaired by a Practitioner or by an audiologist, during the time they are covered.

Benefits are provided for covered hearing devices and for charges associated with fitting and testing. NHP covers the cost of basic hearing aids limited to one hearing aid per ear, including repair or replacement, once every three years. NHP covers the cost of one bone-anchored hearing aid per covered person who meets the following requirements:

a) Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
b) Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Therapy services related to cochlear implants, hearing aids or covered bone-anchored hearing aids have a yearly maximum of 30 visits.

HOME HEALTH CARE SERVICES
NHP covers Home Health Care services only when each of the following applies:

a) A licensed home care program provides the services in Your home.
b) The services provided are skilled nursing or Rehabilitation Services.
c) A Practitioner orders, supervises and reviews the care every two months. The Practitioner may determine that a longer period between reviews is sufficient.

NHP will cover up to 60 visits in a Benefit Year. Each consecutive four hour period that a home health aide provides services is one visit. A Practitioner in NHP's network must order the services.

Physical, occupational and speech therapy rendered in the home will apply to the Home Health Care visit maximum. Nursing services for the administration of injectable medications, including infusions, given in the home are not counted toward the Home Health Care visit limit.

Nursing or Rehabilitation Services may be Palliative Care as long as the services are not Custodial. You do not have to be home-bound to receive services. A service will not be determined to be "skilled" nursing or rehabilitation simply because there is not an available caregiver.

HOME INFUSION SERVICES

NHP covers home infusion services only when a licensed home care or home infusion program provides the services in Your home or at their infusion center.

HOSPICE CARE

NHP covers Hospice care if:

a) Your Practitioner certifies Your life expectancy is about six months;
b) The care is Palliative Care; and
c) The Hospice care is received from a licensed Hospice agency; and
d) Hospice care services are provided according to a written care delivery plan developed by a Hospice care Provider and by the recipient of the Hospice care services.

Hospice care services include, but are not limited to:

a) Bereavement services;
b) Counseling services;
c) Home Health Care services;
d) Medical and social work services;
e) Medical supplies and Durable Medical Equipment;
f) Practitioner services;
g) Nursing care;
h) Nutritional counseling;
i) Occupational, physical or speech therapies;
j) Pain and symptom management;
k) Respite care;
l) Volunteer services;

Respite care can be provided only on an occasional basis (once per 60 Days) and will not be reimbursed for more than five consecutive Days at a time. Services may be provided in a Hospice facility housed in a Hospital, a separate Hospice unit or in Your home. A Hospice facility housed in a Hospital must be in a separate and distinct area.

INPATIENT SERVICES – HOSPITAL/REHABILITATION FACILITY

NHP covers inpatient services and supplies provided in a licensed Hospital or rehabilitation facility. We must receive all details concerning Your care and proposed plan of care. NHP will cover the cost of a Semi-Private room. NHP will cover care in a private room or intensive or coronary care facility only if Medically Necessary.

The Plan covers prescription Drugs provided by a Provider during an Inpatient Stay. Any prescription Drugs taken home or needed following release from Confinement will be subject to the terms and cost sharing of Your pharmacy Benefits described later in this document.

KIDNEY DISEASE SERVICES

NHP will cover chronic renal failure. Coverage includes:

a) Dialysis;
b) Transplantation (see Organ and Tissue Transplant Services below in this section); and
c) Services related to donation when recipient is an NHP Member.

If You have been diagnosed with End Stage Renal Disease (ESRD), please see ARTICLE VIII ~ COORDINATION OF BENEFITS (COB) for more information.

MAMMOGRAPHY SERVICES

NHP will cover low dose screening mammography exams, including 3D mammograms, administered by a Provider. Mammograms can fall under the Preventive Services category for routine mammograms, or mammograms can be Diagnostic in nature in which case cost sharing applies.

MATERNITY AND NEWBORN CARE

Maternity Care

a) NHP covers routine maternity care. Routine services covered include:
    i. Monthly visits up to 28 weeks gestation;
    ii. Biweekly visits from 29 to 36 weeks gestation;
    iii. Weekly visits after 36 weeks until delivery;
    iv. Delivery in a Hospital;
    v. Post-Partum care. Such care includes Hospital and office visits.
b) Abortion procedures to terminate pregnancy if:
    i. Procedure is due to maternal or fetal Illness or Injury; and
    ii. Procedure is in compliance with all applicable laws.
c) Services for medical complications that arise from covered Maternity Care.

For clarification, psychological impact is not a maternal or fetal Illness or Injury covered under paragraph b).

The initial office visit is generally considered to be a Diagnostic Service and not maternity care. Therefore, it may be billed as a diagnostic office visit, separate from other maternity care, and the applicable plan provisions and cost sharing will apply. Your cost sharing may also apply to office visits for services provided in a complicated pregnancy.

NHP will also cover tests to determine the existence of a gender-linked genetic disorder.

We will pay Benefits for an Inpatient Stay of at least:

a) 48 hours for the mother and newborn child following a normal vaginal delivery;
b) 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending Practitioner may discharge the mother and/or the newborn child earlier than these minimum time limits.

Newborn Care

NHP will cover newborn expenses as follows if the newborn is properly enrolled within 60 days of birth as stated in the Special Enrollment provision. If the newborn is not enrolled within the timelines allowed, You will be financially responsible for all costs for the newborn.

Covered Services include:

a) Initial examination of a newborn by the delivery physician.
b) Care for routine nursery charges for a newborn child while the mother is confined in the Hospital.
c) If the enrolled newborn needs to stay in the Hospital after the mother is released from the Hospital, the mother or Provider must call NHP to get Prior Authorization for the newborn's Hospital stay.
d) Circumcisions.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

NHP will cover services for Mental Health and Substance Abuse Disorders. Our coverage includes care related to mental health, alcoholism, chemical dependency or drug addiction.

NHP will cover court-ordered services for Mental Health Disorders and Substance Abuse Disorders. If a Non-Participating Provider provides these Emergency court ordered services, the provider, Member or Member's representative must notify Us within 48 hours or next business day after services begin or when medically feasible to provide notice. We will not cover the services without notice.

NHP covers services for Emergency Mental Health Disorders and Substance Abuse Disorders regardless of where the crisis occurs. NHP covers services for persons experiencing a mental health crisis or in a situation that, if left untreated, would likely become a crisis without proper support.

a) **Outpatient Benefits**
   NHP covers office, clinic, intensive outpatient therapy and outpatient Hospital visits. If necessary for treatment, any covered person may obtain these outpatient Benefits.
b) **Inpatient Benefits**
   NHP will cover inpatient Mental Health Disorder and Substance Abuse Disorder services provided in an appropriately licensed facility such as a Hospital, rehabilitation facility or

other licensed facility. NHP will cover the cost of a Semi-Private Room. NHP must receive all details concerning the care and proposed plan of care.

c) **Transitional Care**
NHP will cover Transitional Care services for Mental Health Disorders and Substance Abuse Disorders including treatment in a Residential Treatment Facility and Intensive Outpatient Therapy. We will cover Transitional Care in a Residential Treatment Facility as an inpatient Benefit (as described above). We will cover Transitional Care provided as Intensive Outpatient Therapy as an outpatient Benefit (as described above).

d) **Outpatient Benefits for College Students**
NHP will cover the following services for Mental Health Disorders or Substance Abuse Disorders:
   i. A clinical assessment of the problem
   ii. Up to five outpatient visits

Services will be covered with Prior Authorization when:
   i. The student is attending school outside NHP's Service Area but within the state of Wisconsin;
   ii. The services are provided by a Non-Participating Practitioner or Non-Participating Provider; and
   iii. The services are provided reasonably close to the school.

You or the Non-Participating Provider must contact NHP to request Prior Authorization for treatment. You are responsible to verify that Prior Authorization is obtained.

If the student is unable to maintain full-time student status, they must obtain services from a Participating Provider for the treatment to be covered. For the purposes of this section, "school" means a vocational, technical and adult education school, or any institution of higher education.

OBESITY TREATMENT
We will cover diet counseling for Obesity, which is a Body Mass Index (BMI) of 30 or higher.

ORAL SURGERY
The Plan will cover oral Surgery for the following medical conditions.

a) Alveolectomy or alveoplasty for treatment related to an Illness or Injury;
b) Excision of benign bony growths of the jaw and hard palate;
c) Excision of tumors and cysts of the jaws, cheeks, lips, tongues, and roof and floor of the mouth;
d) External incision and drainage of cellulites;
e) Frenectomy (incision of the membrane connecting the lip to the jaw or the tongue to the floor of the mouth);
f) Functional osteotomies;
g) Incision of sensory sinuses, salivary glands or ducts; and
h) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

ORGAN AND TISSUE TRANSPLANT SERVICES

NHP covers the following organ and tissue transplant services: medical, surgical, and Hospital services and costs related to obtaining organs. This includes services required to perform the following human organ or tissue transplants.

a) Bilateral sequential Lung
b) Bone Marrow (Autologous self to self or Allogenic other to self)
c) Corneal
d) Health services for a covered person's organ donor, including, but not limited to, compatibility testing for live donors. Donor costs directly related to organ removal are Covered Services for which Benefits are payable through the organ recipient's coverage. These costs are subject to the provisions specified in ARTICLE VIII ~ COORDINATION OF BENEFITS (COB).
e) Heart
f) Heart/Lung
g) Immunosuppressive or anti-rejection medications (These drugs must be for an approved transplant)
h) Intestinal
i) Kidney
j) Kidney/Pancreas
k) Liver
l) Liver/Intestine
m) Pancreas
n) Re-transplantation for the treatment of bone marrow or kidney disease
o) Single lung

OSTOMY SUPPLIES

Benefits for ostomy supplies are limited to the following:

a) Pouches, face plates and belts
b) Irrigation sleeves, bags and ostomy irrigation catheters
c) Skin barriers

OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL SERVICES

NHP will cover outpatient Hospital services such as cardiac rehabilitation, radiation therapy, dialysis, behavioral health and substance abuse. We will also cover surgical procedures at an outpatient Hospital or Ambulatory Surgical Center.

PRESCRIPTION DRUG BENEFITS

Participating Pharmacies

Express Scripts® (ESI) is NHP's Pharmacy Benefit Manager. To find out which pharmacies are considered Participating pharmacies, go to networkhealth.com, select **Find a Pharmacy and click on Start Your Search**. Enter location information and the under Choose plan select Individual (I buy my insurance on my own) This will allow You to look up a pharmacy by pharmacy name, city/state or zip code. Only Participating pharmacies will be shown.

Specific Covered Services

Covered prescription Drug Benefits provided under this Policy include Food and Drug Administration (FDA) approved prescription Drugs dispensed under the guidelines in Network Health's Comprehensive Drug List (CDL)as applicable, and are:

a) Dispensed according to the prescription written by an appropriately licensed Practitioner;
b) Prescription Drugs not designated as Specialty Products filled at or administered by a participating pharmacy, Practitioner's office, home infusion, in the home, infusion center, outpatient facility, or Participating Mail Order Pharmacy Program that is appropriately licensed to dispense prescription Drugs in the United States by the Federal Drug Enforcement Agency and the State. Participating Mail Order Pharmacy Program does not apply to members eligible through an Indian Health Services, Tribal Program, Urban Indian Health Program, or I/T/U Facility;
c) Prescription Drugs You receive as an Inpatient, or as part of an Authorized Home Health Care program, or while a resident in a Skilled Nursing Facility will be eligible for coverage under your medical Benefits;
d) Designated as a Specialty Product and dispensed at a Participating Specialty pharmacy or administered by a participating pharmacy, Practitioner's office, home infusion, in the home, infusion center or outpatient facility;
e) Received in full compliance with ARTICLE IV ~ OBTAINING HEALTH SERVICES;
f) Medically Necessary and appropriate.

Covered Prescription Drugs, including Specialty Products subject to a Copayment or Coinsurance and subject to Deductible and/or Out-of-Pocket Limits shall be covered.

Limitations

Covered prescription drug Benefits are subject to the following limitations:

a) Initial prescriptions or prescription refills obtained from a Participating Retail pharmacy, Participating Specialty pharmacy or Participating Mail Order pharmacy will be covered up to the limits outlined in the Summary of Member Responsibility Table in accordance with directions from the prescribing Practitioner.
b) If the Practitioner indicates "Dispense as Written," or if the Member requests the brand name product for a prescription Drug when an NHP-approved generic is available, the Member must pay the applicable Copayment or Coinsurance plus the Ancillary Fee. The Ancillary Fee is the cost difference between the brand name product and the generic product. The Ancillary Fee may count towards the Deductible and/or Out-of-Pocket Limit. When a generic substitution conflicts with state regulations or restrictions, the pharmacist must gain approval from the prescribing Practitioner to use the generic equivalent. ACA Preventive Drugs may be exempt from the Ancillary Fee when a generic version has been tried, the Practitioner indicates the brand name product is Medically Necessary and Prior Authorization for the $0 cost share has been approved.
c) When applicable, any monetary amount of the Prescription Drug Product covered by a Copay Assistance Card will not apply towards the Deductible and/or Out-of-Pocket Limit.
d) Prescription refills are covered only after 75 percent of the previously dispensed amount is used.
e) In Emergency conditions, prescription Drugs may be dispensed by a Non-Participating pharmacy. You may be required to pay the difference between what You pay for the

prescription drug at the Non-Participating pharmacy and the cost that We would cover at a Participating pharmacy.

f) Prescription drugs for the treatment of HIV will be covered if they are:
   i. Prescribed by an appropriately licensed Practitioner and, either
   ii. Approved by the FDA; or
   iii. In or have completed Phase 3 of the FDA's clinical evaluation and are administered under a protocol approved by the FDA.

g) Certain prescription Drugs (agents, medications, components) are determined and listed by ESI's Pharmacy and Therapeutics (P&T) Committee to have an increased potential for improper use, misuse or abuse. These prescription Drugs require Prior Authorization by NHP. A listing of the prescription Drugs is provided to NHP Practitioners. The list of prescription Drugs can be accessed on networkhealth.com. Prior Authorization must be requested by the covered person or their treating Practitioner before the prescription Drugs will be considered covered. Prescription Drugs may be removed from the list and other prescription Drugs may be added at any time based on the decisions of the P&T Committee.

h) Products designated as Specialty Products on the NHP CDL will be covered subject to the terms and limitations.

i) Prescription Drugs given during a Hospital stay or outpatient visit will be an Eligible Expense under the inpatient or outpatient Benefit.

j) Medications used for convenience purposes, when there are other cost-effective options available, will not be covered.

Definitions

a) ***Specialty Product-*** ESI's P&T Committee may designate pharmaceutical products as Preferred Specialty or Non-preferred Specialty Products. These products will be covered as set forth in the Summary of Member Responsibility Table. Pharmaceutical products designated as Specialty Products will be indicated on the CDL.

b) ***Over-the-Counter Drugs-*** An Over-the-Counter (OTC) drug is a product with ingredient(s) that are available without a prescription.

c) ***Adherence Generics-*** Limited to specific prescription Drugs to treat certain conditions. Pharmaceutical products that have been designated as Adherence Generics will be identified in the CDL.

d) ***Drug Tiers-*** Classification relating to cost sharing for a group of prescription Drugs based on their cost and effectiveness. Tiers and the corresponding cost are covered as set forth in the Summary of Member Responsibility Table.
   i. TIER 0 DRUGS: Preventive Drugs
   ii. TIER 1 DRUGS: Adherence Generics and prescription drugs consisting primarily of generic prescription drugs based on their effectiveness and cost.
   iii. TIER 2 DRUGS: Prescription drugs consisting primarily of preferred prescription drugs based on their effectiveness and cost.
   iv. TIER 3 DRUGS: Prescription drugs consisting primarily of non-preferred prescription drugs based on their effectiveness and cost.
   v. TIER 4 DRUGS: Prescription drugs consisting primarily of preferred specialty prescription drug based on their effectiveness and costs.
   vi. TIER 5 DRUGS: Prescription drugs consisting primarily of non-preferred specialty prescription drug based on their effectiveness and costs.

e) ***Preventive Drugs***- Prescription Drugs and OTC drugs are used for the prevention of certain medical conditions.

f) ***Participating Retail Pharmacy, Participating Mail Order Pharmacy, and Participating Specialty Pharmacy***- A pharmacy that has a contract to provide Benefits to You.

PREVENTIVE SERVICES

We will cover routine evaluation and management of Your health, including routine immunizations. A Practitioner in NHP's network must furnish these services to be covered at no cost share.

NHP pays for:

a) Evidence-based items or services that the United States Preventive Services Task Force (USPSTF) recommends as a grade "A" or "B" in the current recommendations.
b) Routine Immunizations as recommended and determined to be routine for use by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP).
c) Preventive Services including routine screenings for infants, children and adolescents as recommended by the comprehensive guidelines supported by the Health Resources and Services Administration.
d) Well visits for adults and preventive childcare exams for school, camp and sports when done as part of the annual wellness visit.
e) Preventive Services for women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Benefits defined by the Health Resources and Services Administration include comprehensive lactation support and counseling by a trained Provider during pregnancy and/or in the postpartum period. Coverage includes the costs for the rental of breastfeeding equipment. This Benefit does not include coverage for routine pregnancy, delivery and newborn charges.

For a list of covered Preventive Services, log in to Your Network Health account at login.networkhealth.com and click on My Materials to find a link to the Preventive Services Guide. Please refer to this website often, as We have full discretionary authority to change it without notice to You.

PROSTHETIC DEVICES

NHP covers up to ten prosthetic devices that replace a limb or a body part each Benefit Year, this includes repair or replacement of a device, limited to:

a) Artificial arms, legs, feet and hands;
b) Artificial face, eyes, ears and nose;
c) Breast prosthesis.

If more than one prosthetic device can meet Your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for Your needs. The prosthetic device must be ordered or provided by, or under the direction of a Practitioner.

PROVIDER AND PRACTITIONER SERVICES

NHP will cover Provider and Practitioner services for the prevention, Diagnosis or treatment of a bodily Injury or Illness. For example, NHP will cover the following types of services.

a) Administration of drugs, immunizations, allergy testing and injections

b) Anesthesiology services
c) Chemotherapy and radiation therapy
d) Covered Services include medical education services provided in a Practitioner's office by appropriately licensed or registered healthcare professionals when both of the following are true:
   i. Education is required for a disease in which self-management is an important component of treatment.
   ii. There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
e) Foot care limited to metabolic or peripheral disease or if skin or tissue is infected
f) Hearing acuity testing
g) Inpatient rehabilitation facility or Alternate Facility
h) Laboratory, radiology and other Diagnostic Services and testing
i) Lead poisoning screenings
j) Palliative Care services
k) Physical exams, office visits and procedures, Hospital and home visits
l) Scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy
m) Skilled Nursing Facility and residential visits
n) Surgery
o) Tests to determine the existence of a gender-linked genetic disorder

RECONSTRUCTIVE PROCEDURES

NHP will cover Reconstructive Procedures and related Covered Services as necessary:

a) To treat an Injury or Illness or a congenital disease or anomaly that causes a functional bodily impairment.
b) To improve or repair an abnormal condition of a body part that is the result of, or incidental to, a surgery done on that part. This applies only if the initial surgery was for the Diagnosis or treatment of a Covered Service.
c) For breast reconstruction due to a mastectomy as stated above.

REHABILITATION SERVICES – OUTPATIENT

NHP will cover outpatient visits for each of the following categories per Benefit Year:

a) Occupational therapy –20 visits
b) Speech therapy –20 visits
c) Physical therapy –20 visits
d) Pulmonary rehabilitation therapy –20 visits

NHP will only pay for such services if they:

a) Significantly restore function lost due to a covered Illness or Injury;
b) Provide either:
   i. Training in the use of covered prosthetic or orthopedic devices; or
   ii. The ability to care for oneself while restoring the function lost under bullet point a. above. This includes feeding, toilet activities and ambulation.

Rehabilitation Services must be performed by a Practitioner or by a licensed therapy Provider. Benefits under this provision include Rehabilitation Services provided in a Practitioner's office or on an outpatient basis at a Hospital or Alternate Facility.

Services may not be covered if You are no longer making progress in meeting therapeutic goals or if Your treatment goals have been met.

Please note that NHP will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer or Congenital Anomaly. For speech therapy with relation to autism spectrum disorders, please refer to the services described under provision "Autism Services."

ROUTINE PATIENT CARE FOR APPROVED CLINICAL TRIAL

"Approved Clinical Trial" means a study conducted by a Participating Provider, Practitioner or Hospital that is performed to determine if a treatment, procedure, Drug (or combinations of Drugs), or device which might be considered Unproven, Experimental, Investigational, or for Research Purposes or not Medically Necessary may be considered clinically safe and effective to treat the life-threatening disease or condition of the Qualified Member. Only studies approved or funded by the federal governmental agencies listed below will be considered an "Approved Clinical Trial."

a) National Institutes of Health (NIH) Centers for Disease Control and Prevention
b) Agency for Health Care Research and Quality
c) Centers for Medicare and Medicaid Services
d) U.S. Department of Defense
e) U.S. Department of Veterans Affairs
f) U.S. Department of Energy

In addition to the above, a study conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA) may also be considered an Approved Clinical Trial, as well as a study or investigation of a drug trial that is exempt from having such an investigational new drug application.

"Qualified Member" means a Member who:

a) Is eligible for coverage and enrolled in this Policy;
b) Has been diagnosed with cancer or another life-threatening disease or condition;
c) Is accepted into an Approved Clinical Trial; and
d) Has received Prior Authorization to participate in the Approved Clinical Trial from NHP.

In general, We do not cover medical or surgical procedures or devices that are not Medically Necessary or are considered unproven, experimental, investigational or for research purposes. However, You may ask for Prior Authorization to be part of experimental or investigational care. NHP may cover certain routine medical costs for qualified Members who participate in Approved Clinical Trials.

We do not have an obligation to cover certain items and services that are not Routine Patient Care, as determined by the ACA, even when You incur these costs while in an Approved Clinical Trial. Costs excluded from coverage include:

a) The treatment, procedure, Drug (or combinations of Drugs) or device which is being tested if We consider it to be unproven, experimental, investigational, for research purposes or not Medically Necessary;
b) Items and services solely for purposes of data collection and analysis and not for direct clinical treatment or management of the patient;
c) Any service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.

For Covered Services related to an Approved Clinical Trial, cost sharing will apply the same as if the service were not specifically related to an Approved Clinical Trial.

SKILLED NURSING FACILITY (SNF)
Services and supplies provided during an Inpatient Stay in a licensed Skilled Nursing Facility (SNF). Benefits are available for:

a) Supplies and non-Practitioner services received during the Inpatient Stay;
b) Daily (or swing bed) room and board in a Semi-Private Room.

Skilled Care is skilled nursing, skilled teaching and skilled Rehabilitation Services when all the following are met:

a) It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the covered person;
b) It is ordered by a Practitioner;
c) It is not delivered for the purpose of assisting with Activities of Daily Living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair;
d) It requires clinical training in order to be delivered safely and effectively; and
e) The covered person entered the Skilled Nursing Facility within 24 hours of discharge from a covered Hospital Confinement.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Practitioner-directed medical management. A service will not be determined to be “skilled” simply because there is not an available caregiver.

Benefits can be denied or shortened for covered persons who are not progressing in goal-directed Rehabilitation Services or if discharge rehabilitation goals have previously been met.

NHP will not pay for more than 30 Days per Confinement. For Skilled Nursing Facilities, an Inpatient Stay begins on the day of admission into a Skilled Nursing Facility. The 30-Day Skilled Nursing Facility Benefit renews when You haven’t received any inpatient Hospital care or skilled care in a Skilled Nursing Facility for the same or a similar Diagnosis for 60 consecutive Days. If You go into a Hospital or a Skilled Nursing Facility after one Skilled Nursing Facility Benefit period has ended, a new Benefit period begins. However, an additional 30 Days is not available until skilled care has not been required for at least 60 consecutive Days.

TELEHEALTH SERVICES

Some Practitioner services may be performed as a Telehealth Service. We will cover these services under the following conditions:

a) Services performed by a Participating Practitioner.
b) Performed through interactive telecommunications equipment that includes audio and/or video.
c) Telehealth is an appropriate way to access services and an in-person visit is not required.
d) Cost share will be applied the same as indicated for that Covered Service.

Telehealth Services are different than Virtual Visits which have a different cost share and use a defined virtual network.

TEMPOROMANDIBULAR (TMD) DISORDERS

NHP will cover diagnostic procedures and surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of TMD if all the following apply:

a) The condition is caused by congenital, Developmental or acquired deformity, disease or Injury.
b) The services are reasonable and appropriate for the Diagnosis or treatment of TMD. NHP will use the accepted standards of the profession of the treating Practitioner to decide if services are reasonable and appropriate.
c) The service controls or eliminates:
    i. Disease;
    ii. Dysfunction
    iii. Infection; or
    iv. Pain.

NHP limits coverage for diagnostic procedures and non-surgical treatment for TMD to ten services and/or devices per Benefit Year, this is a separate limit from any other therapy services. Non-surgical services include prescribed intraoral splint therapy devices

TOBACCO COUNSELING

NHP will cover the cost of one annual screening and two tobacco-quitting attempts per year. Each attempt includes coverage for up to four tobacco-counseling sessions of at least ten minutes each (including telephone, group and individual counseling) for a maximum of eight tobacco-counseling sessions per year.

NHP also covers specified smoking cessation pharmacy products.

URGENT CARE SERVICES

In the Service Area

If You are in the Service Area You must obtain Urgent Care Services from a Participating Provider or a Participating Urgent Care Facility.

Outside the Service Area

NHP will cover Urgent Care Services provided by a Non-Participating Urgent Care Facility subject to the same cost-sharing requirements that would have applied had a Participating Urgent Care Facility provided such services only if:

a) The Urgent Care Services are provided by the Emergency department of a Hospital or a Hospital-based Urgent Care Facility; or
b) A non-Hospital-based Urgent Care Facility and the Member provide the Urgent Care Services provides the Plan with notification of the Urgent Care Services within one business day of receiving such services. Notification can be provided to NHP by calling the Member Experience number on the back of Your ID Card.

If You receive Urgent Care Services from a Non-Participating Provider or facility that does not meet the above criteria, then Your cost-sharing obligations for Non-Participating Providers will apply.

NHP will not pay for out of area services for the Member's convenience.

A Participating Practitioner must furnish care following an Urgent Care visit. We will not cover Out-of-Network care following an Urgent Care visit that has not been Prior Authorized by NHP.

VIRTUAL VISITS
NHP will cover Telemedicine services that include the Diagnosis and treatment of specified medical and behavioral health conditions through electronic means. Benefits are available only when services are delivered through NHP's defined virtual care contracted Provider, which is indicated on the back of Your ID card. Any prescription Drug the Practitioner deems appropriate will be covered under the pharmacy Benefit.

VISION CARE SERVICES
NHP will cover one basic pair of eyeglasses following cataract surgery. The amount NHP will cover for eyeglasses will not exceed $160 per lifetime. This does not include such items as blended, no-line progressive lenses; polycarbonate lenses; anti-reflective, scratch resistant and ultraviolet (UV) protection; any coating or lamination applied to lenses; tinting; and sunglasses.

VISION CARE SERVICES – PEDIATRIC
We will cover routine eye exams and hardware for children through the end of the month in which they turn 19, through our partnership with EyeMed. The exam may screen for eye disorders and assess the need for prescription corrective or contact lenses. Services will only be covered if received from an EyeMed Participating Practitioner. To search for a pediatric vision provider, visit networkhealth.com/individual/vision-eyemed.

NHP will cover one routine eye exam/eye refraction, frame and lenses each Benefit Year.

Lenses covered in full include the following:
a) Single vision, lined bifocal, lined trifocal or lenticular lenses
b) Polycarbonate lenses
c) Plastic lenses
d) Scratch and UV protection

Frames
Frames from a pediatric exchange collection are covered in full

Contact Lenses
In lieu of eyeglasses, elective contact lenses are covered in full with the following service limitations:

a) Extended Wear Disposables – Up to a six-month supply of monthly or two-week disposable, single vision spherical or toric contact lenses
b) Daily Wear/Disposables – Up to a three-month supply of daily disposable, single vision spherical contact lenses
c) Conventional – One pair from selection of Provider designated contact lenses

Medically Necessary contact lenses are covered in full for children who have specific conditions for which contact lenses provide better visual correction.

EXCLUSION AND LIMITATIONS

ARTICLE VI ~ EXCLUSIONS AND LIMITATIONS

Coverage is not available from NHP for charges arising from the care, supplies, treatment and/or services, including complications, which are listed below. We will not pay for services or supplies that are excluded even if:

a) A Practitioner prescribes, recommends or approves the service or supply.
b) The listed exclusion is Medically Necessary.

SERVICES, TREATMENT, EQUIPMENT AND SUPPLIES NOT COVERED

1. Abortions, the directly intended termination of a pregnancy and all related charges and complications, unless specifically stated in ARTICLE V~ BENEFIT PROVISIONS.
2. Acupuncture, acupressure and similar services, including dry needling, unless specifically stated in ARTICLE V ~ BENEFIT PROVISIONS.
3. Alternative medicine charges including, but not limited to:
    a) Aroma therapy
    b) BEST or AIT therapy
    c) Colonic irrigation
    d) Contact reflex analysis
    e) Electromagnetic therapy
    f) Herbal therapy
    g) Holistic medicine
    h) Homeopathy
    i) Hypnosis
    j) Iridology
    k) Magnetic innervation therapy
    l) Music therapy (unless performed in a behavioral health setting by a licensed mental health professional)
    m) Naturopathy
    n) Neurofeedback
    o) Orthomolecular therapy
    p) Reiki therapy
    q) Thermography
    r) Vitamins or dietary products
4. Ambulance Services that NHP does not cover include:
    a) Non-Emergency transport, unless initiated or approved by NHP.
    b) Services or supplies that are not Medically Necessary, even if provided while in transport.
5. Animal-based therapy, including equine therapy or hippotherapy.
6. Any services or supplies for bodily Injuries sustained while the covered person is committing or attempting to commit a crime punishable as a felony. Any services or supplies arising from the covered person engaging in an illegal occupation or commission or attempted commission on an assault or other illegal act if the covered person is convicted of a crime on account of such illegal assault or other act.
7. Any supplies or services provided for the protection or convenience of or to meet a requirement of third parties. This includes medical, physical, mental health and substance abuse services or examinations. Third parties include, but are not limited to, attorneys, school systems, employers and insurers. This exclusion extends to court-ordered commitments, including sex offender treatment programs and screening interviews or treatment programs related to driving under the influence of alcohol or drugs, mandated

AA and NA meetings and anger management. NHP does not cover health services mandated by a court as a stipulation of parole, probation, sentencing or any other reason, unless Medically Necessary. NHP does provide coverage if mandated pursuant to Wis. Stat. 609.65 wherein an enrollee is examined, evaluated or treated for a nervous or mental disorder pursuant to an Emergency detention, commitment or court order.

8. Any service or expense You incur:
    a) Before Your Effective Date of coverage;
    b) After the date Your coverage terminates; or
    c) After You are disenrolled from NHP.
9. Any service provided by a school system.
10. Any treatment that is not Medically Necessary and appropriate. This applies to any procedure, service, site of care, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
11. Any treatment that is not medical in nature or that is solely for the purpose of athletic performance and/or participation. This applies to any procedure, service, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
12. Any treatment that is provided mainly for the covered person's vocation, comfort, safety, personal hygiene, convenience, exercise, physical fitness or recreation. Any treatment that is provided mainly as an adaptation of the covered person's environment such as ramps, grab bars or that is a common household item such as air-conditioners, humidifiers, dehumidifiers, air purifiers and filters. This applies to any procedure, service, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
13. Any treatment provided in the absence of a bodily Injury or Illness. This applies to any procedure, service, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
14. Any treatment provided or ordered for a covered person themself, by a Family Member or any person residing with the insured. This includes prescriptions, services or supplies. Family Members include Your lawful spouse, child, parent, grandparent, brother, sister or any person related in the same way to Your covered Dependent.
15. Services and treatments for hair analysis, hair removal, hair loss and all forms of alopecia. This applies to any such treatment, procedure, service, device, supply or Drug including Durable Medical Equipment, prosthetic devices and technology. NHP does not cover hair replacements, wigs, toupees and hair replacement therapies.
16. Autism Services We do not cover include:
    a) Animal-based therapy including equine therapy and hippotherapy
    b) Auditory integration training
    c) Care provided in a Residential Treatment Facility, inpatient treatment or day treatment facility
    d) Chelation Therapy
    e) Childcare fees
    f) Cranial Sacral Therapy
    g) Custodial care
    h) Any costs associated with the use of a facility or location when treatment, therapy or services are provided outside of a Member's home
    i) Hyperbaric Oxygen Therapy
    j) Respite care

k) Services rendered by any Practitioner who is not qualified to provide intensive-level services or non-intensive level services
l) Special diets or supplements
m) Treatment rendered by parents or legal guardians who are otherwise Qualified Providers to their own Children
n) Treatments in a school facility that are not related to the goals of the treatment plan or duplicate services that are required to be provided by a school
o) Travel time for Qualified Providers, supervising Providers, professionals, therapists or paraprofessionals

17. Autopsy.
18. Batteries and battery chargers, except for diabetic equipment, covered wheelchairs and implanted devices.
19. Cardiac rehabilitation services We do not cover include:
    a) Stage 3 rehabilitation (Supervised Therapy)
    b) Stage 4 rehabilitation (Maintenance/Follow-Up Therapy)
20. Chimeric antigen receptor (CAR) T-cell and/or gene therapy, including any related services, items and/or drugs.
21. Charges in excess of the Maximum Allowable Fee.
22. Chelation Therapy for autism, Alzheimer's and atherosclerosis.
23. Chiropractic care We do not cover includes:
    a) Any services outlined in alternative medicine exclusions listed above
    b) Maintenance therapy
    c) Massage therapy
    d) Self-help, educational or vocational training treatment, services or supplies
24. Cold laser therapy (also known as low-level light therapy) and similar services. Cold laser therapy is excluded except for the treatment of temporomandibular joint disorders (TMD) dysfunction, rheumatoid arthritis, carpal tunnel syndrome and lateral epicondylitis.
25. Coma stimulation.
26. Complications resulting from leaving a Hospital or other facility or discontinuing treatment against a Practitioner's written orders.
27. Continuous passive motion devices and associated items, such as sheepskin pads and water circulating pumps.
28. Cost of a standby Practitioner.
29. Cost of missed appointments.
30. Cost of release and review of medical records, including copy costs, postage, shipping or handling charges, except when requested by NHP.
31. The cost of communications, lodging and transport or travel time for the covered person or their Family Member(s).
32. Cryopreservation (freezing) of body fluids or tissues.
33. Custodial care, services of personal care attendants or maintenance care.
34. Dental care for Accidents that NHP does not cover includes:
    a) Orthodontia treatment
    b) Restoration of cracked or broken teeth caused by biting or chewing
    c) Services rendered more than 12 months after the date of the Injury
    d) Teeth whitening or bleaching
35. Dental care or treatment except as outlined under ARTICLE V ~ BENEFIT PROVISIONS. Dental damage that occurs as a result of normal Activities of Daily

Living or extraordinary use of the teeth is not considered having occurred as an Accident or Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities. This exclusion applies to:

a) Mouth guards
b) Periodontic care
c) Teeth whitening and bleaching
d) Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly, unless functional repair or restoration is necessary to achieve normal body functioning for newborn infants.

36. Dental implants, dentures, bridges and services for the preparation thereof.
37. Dentist or oral surgeon charges for dental care provided in a Hospital or Ambulatory Surgical . Center other than described in ARTICLE V ~ BENEFIT PROVISIONS are not covered.
38. Durable Medical Equipment (DME) and Disposable Medical Supplies that NHP does not cover includes:
    a) Cords for hearing aids.
    b) DME with features that provide more functions than are Medically Necessary for the covered person. NHP will cover the standard DME model, as determined by NHP.
    c) Motor vehicles or vehicle adaptations, including, but not limited to, lifts for wheelchairs and scooters.
    d) Repairs or replacements of DME, orthotics or prosthetics due to Accidental loss, theft or negligent misuse.
    e) Services, supplies, equipment, accessories or other items which are purchased at retail establishments (including online) or over the counter.
    f) Shoes, orthopedic shoes, shoe orthotics, diabetic shoes, arch supports or shoe inserts, except when custom made.
    g) Self-help devices that are not primarily medical in nature.
39. Enteral feedings including supplies, equipment, formula and additives, even if the sole source of nutrition.
40. Expenses incurred by a non-covered person except for covered services relating to live donor transplants to an NHP Member.
41. Human Chorionic Gonadotropin injections if used to treat a non-Covered Service, such as Infertility.
42. Health club memberships, costs of fitness programs, exercise programs and equipment.
43. Health services provided by Non-Participating Providers and Non-Participating Practitioners. This includes:
    a) Ambulatory non-Emergent, non-Urgent follow-up care provided by a Non-Participating Provider or Non-Participating Practitioner after an Emergency, unless NHP Prior Authorizes the care;
    b) Acute Hospital (Inpatient or observation) follow-up care provided by a Non-Participating Provider or Non-Participating Practitioner after an Emergency, unless NHP Authorizes the care;
    c) Non-Emergency, non-Urgent Care, except as this Policy specifically allows;
    d) Urgent Care Services or treatment provided by a Non-Participating Provider or a Non-Participating Practitioner that is in NHP's Service Area
    e) Out-of-area Urgent Care services for Your convenience.

    This does not apply to:

a) Services provided with NHP's Authorization;
b) Emergency Health Services provided in an Emergency room or Hospital-based Urgent Care Facility when, due to the covered person's location when care became necessary;
c) Urgent Care provided in an Emergency room or Hospital-based Urgent Care Facility outside NHP's Service Area;
d) Services provided by a Non-Participating Provider or Non-Participating Practitioner when received at a Participating Facility or Hospital.

44. Health services for disabilities or conditions resulting from military service, including participation in the National Guard and Civilian auxiliary forces. This applies only if the covered person is legally entitled to services provided by a government agency. Government facilities must be reasonably available. NHP will determine whether services are reasonably available. This exclusion may be limited by federal law.
45. Health services for job, employment or work-related bodily Injuries or Illnesses for which coverage is:
    a) Required under any Workers' Compensation Act or Law;
    b) Required under any Occupational Disease Act or Law;
    c) Provided under a Workers' Compensation policy.
46. Health services received as a result of war or any act of war, whether declared or undeclared or caused while engaged in active military or reservist's duties of any country. This exclusion does not apply to covered persons who are civilians Injured or otherwise affected by war, any act of war or terrorism in non-war zones.
47. Immunizations, exams, prescriptions and health services required solely for purposes of school, sports, camp, travel, licensing, employment, recreation, higher education and insurance, marriage or adoption purposes.
48. Infertility services, artificial conception procedures, supplies and prescriptions which are not for treatment of Illness or Injury (i.e., that are for the purpose of achieving pregnancy). The Diagnosis of Infertility alone does not constitute an Illness. This includes, but is not limited to:
    a) Advanced reproductive technologies. These include in-vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT) and gamete intra-fallopian transfer (GIFT), whose primary purpose is to achieve pregnancy;
    b) Artificial insemination;
    c) Freezing (cryopreservation) of sperm, oocytes or embryos;
    d) In-vitro fertilization;
    e) Intrauterine insemination;
    f) Lab and diagnostic procedures;
    g) Micromanipulation procedures of sperm such as intracytoplasmic sperm injection (ICSI);
    h) Prescriptions;
    i) Procedures related to infertility problems that are considered Unproven, Experimental and Investigational or for Research Purposes;
    j) Reversal of voluntarily sterilization or any related services or complications.
    k) Sperm banking;
    l) Sperm penetration and movement studies.
49. Services for which the covered person is eligible for reimbursement by Medicare are not covered. If You have been diagnosed with End Stage Renal Disease (ESRD), please see ARTICLE VIII ~ COORDINATION OF BENEFITS (COB) for more info.

50. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
51. Maintenance Therapy of any kind. This includes, but is not limited to, physical, speech and occupational therapy.
52. Marriage counseling.
53. Massage therapy.
54. Maternity care We do not cover includes:
    a) Diagnostic tests solely to determine the gender of a fetus.
    b) Births at stand-alone birth centers, home births and all related services.
    c) Childbirth preparation classes, including, but not limited to, Lamaze, hypnobirthing and baby care.
    d) Maternity expenses for a non-covered person acting as a surrogate.
55. Mental Health Services as treatments for conditions or services performed in connection with conditions not classified within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. These include, but are not limited to the following:
    a) Circumstances of personal history
    b) Crime and legal system
    c) Educational and occupational
    d) Housing and economic
    e) Other health service encounters
    f) Other psychosocial, personal and environmental circumstances
    g) Relational
    h) Social environment
    i) Education and literacy
    j) Employment and unemployment
    k) Housing and economic
    l) Social environment
    m) Negative life events in childhood
    n) Problems related to upbringing
    o) Problems related to primary support
    p) Psychosocial circumstances
    q) Other Psychosocial circumstances
56. Neuropsychological testing for Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder.
57. Oral surgery procedures listed below.
    a) Jaw adjustments to correct malocclusion;
    b) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars;
    c) Surgical removal of teeth due to anomalies of tooth position of fully erupted teeth;
    d) Alveolectomy or alveoplasty unrelated to an illness or injury such as preparation for dentures;
    e) Apicoectomy (excision of apex of tooth root);
    f) Treatment of periodontitis and gingivitis;
58. Organ and Tissue Transplant Services We do not cover include:
    a) Any organ or tissue re-transplantation except for kidney re-transplantation for the treatment of kidney disease or bone marrow re-transplantation.
59. Orthodontic services and surgery except for the treatment of TMD.

60. Ostomy supply Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items not listed in the Benefits Provisions section.
61. Payment for services not billed in accordance with Our payment policies, which are based on Current Procedural Terminology (CPT®) billing requirements, regulations promulgated by Center for Medicare and Medicaid Services (CMS) or other coding guidelines. Our payment policies take into consideration factors such as coding practices, industry-standard reimbursement logic and applicable legal requirements.
62. Pediatric Dental Services as required under the federal Patient Protection and Affordable Care Act.
63. Pediatric Vision services that are not covered include:
    a) Therapy including eye exercises (orthoptic and pleoptic) and aids.
    b) Two pairs of glasses instead of bifocals.
    c) Replacement of lenses, frames or contacts.
    d) Items not covered under the contact lens coverage includes:
        i. Insurance policies or service agreements.
        ii. Artistically painted or non-prescription lenses.
        iii. Additional office visits for contact lens pathology.
        iv. Contact lens modification, polishing or cleaning.
64. Prayer or spiritual healing.
65. Prescription Drug Benefits not covered include:
    a) Over-the-counter (OTC) Drugs and supplies with or without a prescription, unless specifically listed in the most recent edition of the Comprehensive Drug List (CDL); prescription drugs comprised of components available in OTC form or equivalent unless specifically listed in the most recent edition of the CDL; and certain prescription drug products that have been determined to be therapeutically equivalent to an OTC drug.
    b) Prescription drugs prescribed for treatment of Infertility.
    c) Experimental or other FDA-approved prescription Drugs, including compounded prescription Drugs to be used for experimental purposes or unapproved routes of administration. This excludes prescription Drugs for the treatment of HIV that are:
        i. Prescribed by a Practitioner and, either
        ii. Approved by the Food and Drug Administration (FDA); or
        iii. In or have completed Phase 3 of the FDA's clinical evaluation and are administered under a protocol approved by the FDA.
    d) Prescriptions or refills required by a covered person because of theft, damage or loss of the prescription.
    e) Prescriptions or refills exceeding dispensing limitations, for vacation, travel or other periods of extended duration, unless Prior Authorization is given by NHP.
    f) Prescription drugs for home use dispensed prior to your release by Home Health Care Services, Inpatient services, Skilled Nursing Facilities or Practitioner's office are not covered.
    g) Prescription Drugs dispensed outside the United States, except when required for Emergency treatment.
    h) Prescription Drugs received from the local, state or federal government. In addition, prescription Drugs where payment or Benefits are provided at the local, state or federal government level (e.g., Veterans Affairs benefits) except as otherwise mandated by law.

i) Prescription Drugs for a condition, Injury, sickness or mental Illness related to any workers' compensation law or other similar laws, if a Claim for such Benefits is made.
j) Any product dispensed for appetite suppression or weight loss.
k) Durable Medical Equipment with or without a prescription other than items specifically stated as covered in the CDL.
l) Vitamins, except prescription items and OTC products covered by the ACA, such as prenatal vitamins, vitamins with fluoride and certain single-entity vitamins.
m) Unit dose packaging of prescription Drugs.
n) Prescription Drugs used for cosmetic purposes.
o) Bulk powders.
p) Any prescription Drug purchased from the original Drug manufacturer and placed into different containers. These are commonly referred to as "repackaged Drugs."
q) New prescription Drugs and/or new dosage forms until the date they are assigned to a Tier by the P&T Committee.
r) Prescription compounded Drugs that do not contain at least one ingredient approved by the FDA and not otherwise excluded from coverage by NHP as experimental. Compounded Drugs that are available as a comparable commercially available prescription Drug.
s) Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
t) Any product for which the primary use is a source of nutrition or dietary management of disease. These products include nutritional supplements and prescription medicinal food products, even when used for the treatment of Sickness or Injury.
u) Prescription Drugs for sexual dysfunction.
v) A prescription Drug or dosage form that NHP determines does not meet the definition of a Covered Service. This may include Drugs that are therapeutically equivalent or have modified versions of a prescription Drug. The P&T Committee may make these determinations. NHP may decide at any time to reinstate Benefits for a prescription Drug previously excluded under this provision.
w) Prescription Drugs that have not received FDA approval may not be covered as determined by the P&T Committee. These prescription Drugs may also be known as Non-FDA approved Drugs or DESI Drugs (Drug Efficacy Study Implementation).
x) Prescription Drugs for the desensitization of environmental and food allergies (e.g., Palforzia).]

66. Private Duty Nursing.
67. Private room charges unless no semi-private room is available.
68. Routine foot care. This includes, but is not limited to, trimming corns and calluses, hypertrophy or hyperplasia of the skin and subcutaneous tissue of the feet and nails. This also includes other hygienic and preventive maintenance care, such as cleaning and soaking the foot, use of skin creams to maintain covered person's skin tone and any other service performed in the absence of localized Illness, Injury or symptoms involving the foot. NHP does cover services for a metabolic or peripheral disease or if skin or tissue is infected.
69. Self-help, educational or vocational training, treatment, services or supplies.

70. Services for which You are eligible for reimbursement by Medicare are not covered. If You have been diagnosed with End Stage Renal Disease (ESRD), please see ARTICLE VIII ~ COORDINATION OF BENEFITS (COB) for more information
71. Services and supplies for which You have no legal obligation to pay, no charge is made or for which You would not be required to pay if You did not have this coverage.
72. Services or supplies the covered person receives, which are paid, may be paid, are provided or may be provided at no cost to the covered person through any program or agency. It also includes care provided at government expense under any program for which the covered person is eligible. Examples of these types of services include but are not limited to the following.
    a) Services provided under a Worker's Compensation policy.
    b) Services received as a veteran in a Veteran Administration facility.
    c) Services provided by a university student health center.

    This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.
73. Services, supplies, equipment, accessories or other items which can be purchased at retail establishments (including on-line) or over the counter.
74. Services solely to improve the covered person's appearance. NHP will not pay for services that are not for the correction of a functional defect caused by a bodily Injury or Illness. This includes reconstructive, plastic, cosmetic surgery or any other service or supply which is primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for:
    a) Repair or alleviation of damage resulting from an Accident;
    b) Because of infection or Illness;
    c) Due to congenital disease, Developmental condition or anomaly of a covered Dependent child which has resulted in a functional defect; or
    d) Breast reconstruction as allowed under the Women's Health and Cancer Rights Act.

    Psychological impact is not a functional defect caused by a bodily Injury or Illness. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.
75. Services that are not Medically Necessary, to include services that are Fraudulent, Wasteful or Abusive Practices.
76. Services performed by a Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided in the Plan.
77. Skilled Nursing Facility services that can be provided at an ambulatory or home care level.
78. Sublingual (under the tongue) allergy testing and treatment.
79. Treatment or surgery received outside the United States, except for emergency situations.
80. The reversal of any transgender or gender dysphoria surgery.
81. The following services related to the treatment of Temporomandibular (TMD) Disorders**.**
    a) Any procedure, device or treatment for plastic surgery or Cosmetic Procedures or to improve one's appearance.

b) General dental care.
c) Periodontic care.

82. Treatment and prescription Drugs for obesity including, but not limited to, weight loss or weight management programs and bariatric procedures such as ileal bypass, gastric bypass or stapling and complications from such procedures.
83. Treatment of flat feet and treatment of subluxation of the foot, including any DME and disposable medical supplies.
84. Treatment of sexual or erectile dysfunction (including impotence). This includes any procedure, service, supply, Drug, device or technology used to treat these conditions.
85. Treatment and/or services related to a non-covered Benefit, including complications from treatment of a non-covered Benefit.
86. Treatment for gambling addiction.
87. Treatment and services for Rett's Disorder and sensory integration or defensiveness.
88. Treatment or services provided and/or billed by an adult or child daycare organization.
89. Treatment or services which are not provided or supplied by a Provider under the direction of a Practitioner.
90. Tuition for or services that are school based for children and adolescents under the Individuals with Disabilities Education Act.
91. Drugs, Medical or surgical procedures that are considered unproven, experimental, investigational or for research purposes. This includes service levels that are not appropriate to the procedure or services, based on national standards. This applies to complications from such procedures. NHP's Medical Director will make such determinations. NHP will base its decisions on generally accepted standards of the U.S. medical community. A service, supply, treatment or facility may be considered unproven, experimental or investigational or for research purposes even if the Practitioner has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition
92. Vision services not covered include:
    a) Vision therapy, including eye exercises (orthoptic and pleoptic) and aids.
    b) Surgery to correct vision. This includes, but is not limited to:
        i. Astigmatic Keratotomy (AK);
        ii. Automated Lamellar Keratoplasty (ALK);
        iii. Corneal modulation;
        iv. Excimer Laser;
        v. Laser Assisted In Situ Keratomileusis (LASIK);
        vi. Photorefractive Keratotomy (PRK);
        vii. Phototherapeutic Keratotomy (PTK);
        viii. Radial Keratotomy (RK) and;
        ix. Refraction Keratoplasty.
93. Work Hardening Services, which are a Rehabilitation Services program designed to restore functional and work capacities to the injured worker through application of graded work simulation.

ARTICLE VII ~ COMPLAINT AND GRIEVANCE RESOLUTION

NHP designed this Complaint and Grievance Resolution process to protect Your rights.

If You have a question or Complaint about any decision NHP makes, including a Coverage Denial Determination or if You have any other question or concern about NHP, contact an NHP Member Experience representative at the number on the back for Your ID card. The Member Experience representative will try to answer Your question or resolve Your concern. If You are not satisfied, You may file a Grievance.

Grievances received by Us are forwarded to Our Appeals and Grievance Department for resolution.

GRIEVANCE PROCEDURES

NHP follows procedures designed to provide You a reasonable opportunity for a full and fair review of Your Grievance.

a) You must file a Grievance by sending a written explanation of Your concerns to NHP at 1570 Midway Pl., Menasha, WI 54952 . We will accept Grievances until three years after the time proof of loss is required to be provided, as described in ARTICLE 1 ~ GENERAL PROVISIONS of this document.
b) We will acknowledge Your Grievance in writing within five business days of receiving it.
c) We will appoint a Grievance committee to review Your Grievance. The committee will not include any person who made the initial Benefit determination.
d) We will notify You at least seven Days in advance of the time and date that the Grievance committee will hear Your case.
e) You have (or a representative You authorized has) the option to appear in person before the Grievance committee to present any information to support Your position, including written comments, documents, records and other information. If You are (or Your authorized representative is) unable to attend, You (or Your authorized representative) may attend telephonically. You (or Your authorized representative) may ask questions of Grievance committee members at that time.
f) NHP will take into account all comments, documents, records and other information You submit that are relevant to the Claim, without regard to whether We received or considered that information in Our prior Benefit determination.
g) If Your Grievance concerns a Coverage Denial Determination that is based, in whole or in part, on a medical judgment, the Grievance committee will consult with an independent health care professional. The independent health care professional will have appropriate training and experience in the field of medicine related to the medical judgment. The independent health care professional will not be the same person with whom We consulted in the initial Coverage Denial Determination or the subordinate of such person.
h) We will notify You in writing of the results of the Grievance review. A member of the Grievance committee will sign the written notice. We will send the notice within the time periods outlined below, and according to the procedures described in this document.

Type of Grievance	Initial Time Period	Extended Time Period
Post-Service Claim	Within a reasonable period of time, no later than 60 Days after receipt of the request for review.	None.

Pre-Service Claim	Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 Days after receipt of the request for review.	None.
Written Grievance not related to Coverage Denial Determination	Within 30 Days after receipt of the request for review.	A 30 Day extension, not to exceed a maximum of 60 Days.

i) If NHP cannot address Your Grievance within the initial time periods described above, We will notify You in writing. Your written notice will state why more time is required and when You can expect the matter to be resolved. If more time is required to address Your Grievance, NHP will resolve the matter within the extended time periods described above.

EXPEDITED URGENT GRIEVANCE (APPEAL)
If Your Grievance involves clinical urgency, You, Your Practitioner or Your representative may request Your Grievance to be expedited.

An Expedited Grievance is a Grievance where the standard resolution process may include any of the following:

a) Serious jeopardy to Your life or health or Your ability to regain maximum function;
b) In the opinion of a Practitioner with knowledge of Your medical condition, You would be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance;
c) It is determined to be an Expedited Grievance by a Practitioner with knowledge of Your medical condition.

NHP's expedited process requires a decision to be made as expeditiously as the medical condition requires, but no later than, 72 hours after receiving the request. The Practitioner will be contacted verbally with the initial notification of the decision within the 72 hour time limit. Written notification of the decision will be mailed to You and the Practitioner no later than three Days from the verbal notification.

NHP may obtain medical advice and/or medical reviews when necessary and appropriate to evaluate Your Grievance.

RIGHT TO REQUEST AN INDEPENDENT REVIEW
You may have the right to have an independent review of certain final decisions made by NHP. If You (or a representative on Your behalf) request an independent review, an Independent Review Organization (IRO) will process Your Grievance. The only Grievances eligible for independent review are Grievances of Coverage Denial Determinations (including expedited reviews of Coverage Denial Determinations) that involve:

a) Medical judgment, including NHP's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered Benefit,

or NHP's determination that a treatment is unproven, experimental, investigational or for research purposes.

b) A rescission of Your Policy.
c) Denied coverage for a Non-Participating Provider or a Non-Participating Practitioner, but You feel the clinical expertise of the Non-Participating Provider or the Non-Participating Practitioner is Medically Necessary.

Requests for services that are not included in Your Benefit package are ineligible for independent review (including, but not limited to, Benefit limitations and direct exclusions).

Generally, You must complete NHP's internal Grievance process before You can initiate an independent review. You do not need to complete the internal Grievance process; however, if Your Coverage Denial Determination qualifies for the Expedited Grievance and You request an immediate independent review, We may agree to proceed if We conclude it is in everyone's best interests.

To request an independent review, You must send Your written request to NHP within four months of the date on which You receive NHP's written response to Your Grievance or the Coverage Denial Determination, whichever is later. If You do not notify NHP of Your request for independent review within the four months, Your case is no longer eligible for independent review. Your written request must include the following.

a) Your name, address and telephone number.
b) An explanation of Your disagreement with the Coverage Denial Determination.

In an Urgent Care situation, Your request for independent review does not have to be in writing and will be expedited. You may also request to have the Grievance Committee review an Urgent Care situation at the same time as the IRO to save time. When NHP receives Your request for independent review, We will perform a preliminary review to determine whether Your request is eligible for review. NHP will complete the preliminary review within five business days (as soon as possible for an expedited review) and notify You of its determination within one additional business day (as soon as possible for an expedited review). If Your request is not eligible for independent review, NHP will explain the reasons why it is not eligible and any information You may provide to make Your request eligible. If Your request is eligible for independent review, We will randomly assign Your case file to one of three contracted (IROs) to process Your Grievance.

Generally, the IRO's decision is binding on both Us and You, except to the extent other remedies are available under state or federal law. If the Coverage Denial Determination involved in the decision relates to the rescission of coverage, then, the decision is not binding on You. In that case, You may be eligible for binding arbitration.

BINDING ARBITRATION

If Your Grievance remains unresolved after completion of the Grievance process, You may submit Your Grievance to binding arbitration as allowed by the Wisconsin Arbitration Act. You are responsible to pay for one-half of the cost of arbitration. Grievances reviewed by an IRO are not eligible for binding arbitration except those concerning rescission of coverage.

ADVERSE BENEFIT DETERMINATION

Adverse Determination means a determination by or on behalf of NHP to which all the following apply:

a) An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered Benefit has been reviewed;
b) Based on information provided, the treatment does not meet NHP's requirements for Medical Necessity, appropriateness, health care setting or level of care or effectiveness;
c) Based on information provided, NHP has reduced, denied or terminated treatment or payment for the treatment.

An Adverse Benefit Determination includes those in which coverage for a Non-Participating Provider or a Non-Participating Practitioner were denied, but You feel the clinical expertise of the Non-Participating Provider or the Non-Participating Practitioner is Medically Necessary.

COORDINATION OF BENEFITS (COB)

ARTICLE VIII ~ COORDINATION OF BENEFITS (COB)

NHP will coordinate Benefit payments with other health care coverage You may have, as set forth below. The purpose of this provision is to ensure You receive the Benefits to which You are entitled without providing more Benefits than the total cost of care received.

APPLICABILITY

a) This Coordination of Benefits (COB) provision applies to This Plan when a covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.
b) If this COB provision applies, the order of Benefit determination rules shall be looked at first. The rules determine whether the Benefits of This Plan are determined before or after those of another Plan. The Benefits of This Plan:
    i. Shall not be reduced when, under the order of Benefit determination rules, This Plan determines its Benefits before another Plan; but
    ii. May be reduced when, under the order of Benefit determination rules, another Plan determines its Benefits first.

DEFINITIONS SPECIFIC TO COORDINATION OF BENEFITS

a) "Allowable Expense" means a necessary, reasonable and customary item of 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.
b) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.
c) "Plan" means any of the following which provides Benefits or services for, or because of, medical or dental care or treatment:
    i. Group insurance or group-type coverage, whether insured or self-funded, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
    ii. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.
    iii. Individual policies sold on and off the Health Insurance Marketplace, grandfathered individual plans and transitional (aka, grandmothered) individual plans.
d) "Primary Plan"/"Secondary Plan". The order of Benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.
    i. 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.
    ii. 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.

iii. 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 DETERMINATION
The rules below determine which health plan is primary and which health plan is secondary.

a) No COB provision: If the Member's other health plan does not have a COB provision, that Plan will be primary.
b) Non-Dependent/Dependent: A Primary Insured's Plan will be primary over a Plan that covers that Primary Insured as a Dependent.
c) Dependent children: The "Birthday Rule" will determine which Plan is primary for a Dependent child with coverage under both parents' Plans.

Birthday Rule
The Plan of the parent whose birth date occurs first in a calendar year is primary. If both parents have the same birth date, the Plan that has covered the parent for a longer period of time is primary.

Dependent Children with Unmarried, Separated or Divorced Parents
The rules below determine which health plan is primary for a child for whom a court order awards custody to one parent. The rules below only apply after NHP has been informed of the court ordered terms.

a) The Plan of the parent with custody of the child is primary.
b) If the custodial parent has no Plan, the Plan of the custodial parent's spouse is primary.
c) If neither the custodial parent nor their new spouse has a Plan, the Plan of the parent who does not have custody of the child, or their spouse is considered primary.

If the specific terms of a court decree state that the parents have joint custody and do not specify which parent is responsible for health care expenses, the Birthday Rule will apply.

If a court decree orders that one parent is responsible for health care expenses, the Plan of that parent will be primary.

ACTIVE/INACTIVE EMPLOYEE
If a spouse is laid off or retired, a Plan that covers an actively at work spouse is primary for the inactive spouse and their Dependents.

CONTINUATION OF COVERAGE
The Plan that covers a person as an actively at work employee or Dependent is primary over any continuation of coverage Plan.

LONGER/SHORTER LENGTH OF COVERAGE
If none of the above rules determines the order of Benefits, the Plan that has covered the person for a longer period of time will be primary.

EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY
We will apply the provisions of this COB section to Allowable Expenses payable under both NHP and any other Plan. To be eligible, You must incur the Allowable Expenses while You are

covered by NHP and Claims must be submitted to Us within 90 Days of receipt of the primary health plan's Explanation of Benefits. These provisions apply only when the sum of the amount NHP covers for Allowable Expenses and the amount of Allowable Expense any other Plan covers, in the absence of this COB section or any similar provision in the other Plan, exceed the amount of Allowable Expenses.

NHP will cover Allowable Expenses incurred by You while You are covered by NHP as follows:

a) If NHP is primary, We will pay Benefits without regard to any other Plan;
b) If another Plan is primary, We will reduce Benefits so that total Benefits payable by all Plans will not exceed the total of Allowable Expenses.

COB WITH MEDICARE

The section above "EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY" notwithstanding, when Medicare is primary, total Benefits payable by NHP shall not exceed the Member's Out-of-Pocket liability under Medicare or this NHP Plan, whichever is lesser. COB with Medicare will conform to federal and state statutes and regulations.

If You are diagnosed with End Stage Renal Disease (ESRD), this Plan will be primary during the first 30 months, beginning the initial month of Medicare eligibility, as determined by the Social Security Administration. Following the 30-month coordination period, this Plan shall pay secondary for all Benefits reimbursable by Medicare.

RIGHT TO NECESSARY INFORMATION

We may need information to determine proper payment. NHP may obtain that information from any organization or person without Your consent but will do so only as needed to apply these COB rules. We may give necessary information to another organization or person in order to coordinate Benefits. NHP uses and discloses confidential medical and patient information only as state and federal law allows. Medical records remain confidential as provided by state law. Each person claiming Benefits under This Plan must give NHP any facts it needs to pay the Claim.

FACILITY OF PAYMENT

NHP may directly pay another Plan that pays an amount We should have paid. That amount will then be treated as though it were a Benefit paid under This Plan. NHP 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 TO RECOVERY

NHP may recover payments We make that are in excess of the amount owed. You grant NHP a lien against any amounts We pay to You or to a third party on Your behalf and NHP will recover from You or such third party an amount equal to the excess payment made under this Article.

EFFECT ON BENEFITS DURING A HOSPITALIZATION

If your Effective Date of coverage with NHP occurs during a hospitalization, the prior carrier is responsible for covered facility charges if billed as a bundled charge called a Diagnosis Related Group (DRG). However, if the facility charges are not submitted as a DRG Claim or the prior carrier declines to pay it as such, NHP will only be responsible for facility charges incurred while You were covered by NHP. If Your coverage with NHP terminates during a

hospitalization, NHP is responsible for covered facility charges through discharge if billed as a DRG. We are only responsible for non-facility charges that are Covered Services during the actual time You are covered.

ARTICLE IX ~ TERMINATION OF COVERAGE

TERMINATION OF COVERAGE

Policyholder's Insurance

This Policy shall terminate on the earliest of the following dates:

a) You may terminate Your coverage by filing a request for termination to NHP. If Your Policy was purchased through the Health Insurance Marketplace You must contact them directly to request Your termination; or
b) The date We have determined the Policyholder to have committed an act of fraud or made an intentional misrepresentation of material fact; or
c) The date the Policyholder no longer resides in the Service Area or in an area that NHP is authorized to do business. Coverage will be terminated only if done uniformly without regard to any health status related factors; or
d) The first date following 90 Days advance written notice by NHP to the Policyholder when NHP may lawfully discontinue offering policies of this type in the state of Wisconsin; or
e) The first date following 180 Days advance written notice by NHP to the Policyholder when NHP may lawfully discontinue offering all health insurance coverage in the individual market in the state of Wisconsin; or
f) The date this Policy ceases to be a Qualified Health Plan and is decertified by the Health Insurance Marketplace or the date We terminate as a Qualified Health Plan Issuer; or
g) The date of the Policyholder's death.

Dependent Insurance

The insurance coverage of a Dependent shall terminate on the earliest of the following dates:

a) You may terminate Your Dependent(s) coverage by filing a request for termination to NHP. If the Policy was purchased through the Health Insurance Marketplace You must contact them directly to request Your Dependent(s) termination; or
b) Dependent coverage will terminate at the end of the year of their 26th birthday.
c) The date the Policyholder's Dependent has been determined by NHP to have committed an act of fraud or made an intentional misrepresentation of material fact; or
d) The date the Policyholder no longer resides in the Service Area or in an area that NHP is authorized to do business. Coverage will be terminated only if done uniformly without regard to any health status related factors; or
e) The first date following 90 Days advance written notice by NHP to the Policyholder when NHP may lawfully discontinue offering policies of this type in the state of Wisconsin; or
f) The first date following 180 Days advance written notice by NHP to the Policyholder when NHP may lawfully discontinue offering all health insurance coverage in the individual market in the state of Wisconsin; or
g) The date of the Dependent's death.

The attainment of the limiting age by a covered Dependent will not cause coverage to terminate while that person is and continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and chiefly dependent on You for support and maintenance.

TERMIINATION OF COVERAGE

Continuation of Coverage
If a Dependent's coverage terminates as the result of the death of the Policyholder, or the severance of the family relationship because of annulment or valid decree of divorce, a Dependent may continue coverage without providing evidence of insurability by making the required Premium payments for issuance. The eligible Dependent must submit a new application for this continuation of coverage within 31 Days of the date on which coverage would otherwise terminate.

DISENROLLMENT OF COVERAGE
NHP will terminate Your coverage if:

a) You fail to pay Premiums in accordance with this Policy;
b) You, as the Policyholder, no longer reside in the NHP Service Area;
c) You perform a Fraudulent act or practice (including, but not limited to, allowing another person to use Your ID card or making an intentional misrepresentation of material factor in connection with coverage).

NHP will terminate coverage at a future date, except in the event of a Fraudulent act or practice as described under paragraph c), in which case, NHP will rescind coverage.

We will terminate Your coverage if NHP ceases to be eligible to offer such coverage under federal or state law.

ARTICLE X ~ RECOVERY RIGHTS

WORKERS COMPENSATION (WC)

If we erroneously pay for services which may be reimbursable by WC, You agree to reimburse Us the value of the services. We may recover payments even if:

a) The WC benefits are disputed or are obtained through settlement or compromise;
b) No final decision is made that the bodily Injury or Illness took place in the course of or resulted from employment;
c) The Member or the WC carrier disputes the amount of WC due or the amount is not defined; or
d) The WC settlement or compromise excludes medical or health care Benefits.

No one may enter into a compromise or hold harmless agreement relating to NHP's paid Claims without Our express written consent. This is the case whether the WC insurer disputes such Claims or not.

SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when We have paid Benefits on Your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means We are substituted to and shall succeed to any and all legal Claims You may be entitled to pursue against any third party for the Benefits We have paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement occurs when a third party causes or is alleged to have caused a Sickness or Injury for which You receive a full or partial settlement, judgement or other recovery from any third party. You must then use remaining proceeds to return to Us 100 percent of any Benefits You received for that Sickness or Injury, with such proceeds available for collection to include any and all amounts paid as non-economic damage judgment or settlement.

The following persons and entities are considered third parties:

a) A person or entity alleged to have caused You to suffer a Sickness, Injury, or damages, or who is legally responsible for the Sickness, Injury, or damages.
b) Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury, or damages.
c) The plan sponsor.
d) Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
e) Any person or entity liable for payment to You on any equitable or legal liability theory.

You agree as follows:

a) You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to, the following.
   i. Notifying Us, in writing, of any potential legal claim(s) You have against any third party for acts which caused Benefits to be paid or become payable.
   ii. Providing any relevant information requested by Us.
   iii. Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement Claim.
   iv. Responding to requests for information about any Accident or Injuries.
   v. Making court appearances.
   vi. Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.

Complying with the terms of this Article

a) We may, at Our option, take necessary and appropriate action to preserve Our rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in Your name, which does not obligate Us in any way to pay You part of any recovery We might obtain.
b) You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
c) We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
d) In the case of Your wrongful death or survival claim, the provisions of this Article apply to Your estate, the personal representative of Your estate and Your heirs or beneficiaries.
e) Your failure to cooperate with Us is considered a breach of contract. As such, We have the right to:
   i. Terminate Your Benefits;
   ii. Deny future Benefits;
   iii. Take legal action against You;
   iv. Offset from any future Benefits the value of Benefits We have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan;
   v. Recover any attorneys' fees and costs incurred by Us in order to collect third-party settlement funds held by You or Your representative.
f) No allocation of damages, settlement funds or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100 percent of its interest unless the Plan provides written consent to the allocation.
g) The provisions of this Article apply to the parents, guardian or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian brings a Claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that Claim.

h) If a third party causes or is alleged to have caused You to suffer a Sickness or Injury while You are covered under this Plan, the provisions of this Article continue to apply, even after You are no longer covered.
i) We have a first priority right to receive payment on any Claim against a third party before You receive payment from that third party. Further, Our first-priority right to payment is superior to any and all Claims, debts or liens asserted by any medical Providers, including but not limited to, Hospitals or Emergency treatment facilities, which assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
j) The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.
k) The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments or other recoveries paid or payable to You or Your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic and punitive damages. The Plan is not required to help You pursue Your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from Our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
l) We may collect from You the proceeds of any full or partial recovery You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which We may collect include, but are not limited to, economic, non-economic and punitive damages.
m) If You receive any payment from any party as a result of Sickness or Injury, and We allege some or all of those funds are due and owed to Us, You shall hold those funds in trust, either in a separate bank account in Your name or in Your attorney's trust account. You agree that You will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
n) The Plan's rights to recovery will not be reduced due to Your own negligence.
o) Upon Our request, You will assign to Us all rights of recovery against third parties, to the extent of the Benefits We have paid for the Sickness or Injury.

ARTICLE XI ~ GENERAL PROVISIONS

ADMINISTRATION
NHP will adopt, interpret, and apply any rules necessary to administer this coverage. NHP does not require consent for adopting, interpreting, or applying these rules. Any action or decision issued by NHP will be conclusive and binding on all persons, except as otherwise provided in ARTICLE VII~ COMPLAINT AND GRIEVANCE RESOLUTION. NHP may subcontract the administration of all or part of this Policy to a third party.

NHP IDENTIFICATION (ID) CARDS
NHP ID cards are for identification purposes only and does not alone entitle a cardholder to Benefits. NHP may revoke coverage of a Member who allows unauthorized use of an NHP ID card.

AMENDMENTS
NHP reserves the right, in our sole discretion and without Your approval, to change, interpret, modify, withdraw or add Benefits or terminate this Policy to the extent permitted by law.

Any provision which, on its Effective Date, conflicts with the requirements of applicable state or federal statutes or regulations is hereby amended to conform to the minimum requirements of such regulations.

All other changes must be made in writing and signed by one of Our officers. No agent has the authority to change or waive any of the provisions in the Policy.

NON-DISCRIMINATION
NHP will not discriminate in violation of state or federal law in denying coverage to any eligible Policyholder or Dependent. NHP will not discriminate in violation of any State or Federal law in administering Benefits.

RIGHT TO EXCHANGE INFORMATION
Except as prohibited by state or federal law, NHP may obtain and provide to any person or organization all medical information and records necessary to administer Benefits.

PHYSICAL EXAMINATION
At NHP's request and expense, a Member must submit to a physical exam for purposes of:
a) Determining eligibility for claimed services and Benefits, and
b) Recovery rights (See ARTICLE X~ RECOVERY RIGHTS)

You or Your representative waives all rights to refuse consent for such examination.

GOVERNING LAW AND LEGAL ACTIONS
Legal action may not be brought until the earliest of:
a) 60 Days after written proof of loss is provided.
b) 60 Days after written proof of loss is required to be provided.
c) NHP waives the need for such proof of loss in writing.
d) NHP's denial of payment.

Legal action may not be brought more than three years after the earliest of these dates. NHP delivered this Policy in Wisconsin and it shall be governed by and construed in accordance with the internal laws of the State of Wisconsin, without regard to conflict of laws principles.

ASSIGNMENT OF BENEFITS
Your coverage and rights under this Policy may not be assigned. Network Health has the right to pay benefits under this Policy to a Provider and may do so directly or otherwise at its discretion. However, payments made in Our discretion to a Provider shall not be construed as an assignment or grant third party beneficiary status to Provider.

CLERICAL ERRORS
Verbal or written clerical errors will not change the rights or obligations of any party.

HEADINGS
The use of titles, headings or sections is for Your convenience and carries no weight in interpreting the contents of this document.

PROOF OF LOSS
NHP will accept only Claims that are in English and converted to United States currency. All Claims must be in writing. Claims must be submitted within 90 Days of service. When NHP is the secondary payer, coordination of Benefits must be submitted to NHP within 90 Days after receipt of the primary payer's explanation of Benefits. If it is not reasonably possible for You to submit Your Claim within the 90 Days, NHP will still accept Your Claim until one year after the 90 Days.

NON-WAIVER AND SEVERABILITY
NHP's delay or failure to exercise/seek a remedy or right will not impair or waive NHP remedies or rights or affect any subsequent remedy or right NHP may have.

A finding that a provision is unenforceable or invalid for any person or circumstance will not make the provision unenforceable or invalid for any other person or circumstance. An unenforceable or invalid provision will not make the remainder of this document invalid or unenforceable.

Only NHP may waive any term or provision. NHP will only do so in writing. Only an authorized employee or representative of NHP may sign such a written waiver. No oral representation of any employee or representative of NHP is sufficient to waive, modify or amend any term or provision.

CONTINUITY OF CARE
NHP will protect the continuity of care You receive from Practitioners NHP lists as participants in its network during Your open enrollment under the following circumstances. These continuity of care provisions do not apply to a Practitioner terminated for professional misconduct or one who stops practicing in NHP's Service Area.

a) **Primary Care Practitioner (PCP)**

If the Practitioner is Your PCP and Your PCP's relationship with NHP ends, then NHP will treat Your PCP as a Participating Practitioner until the end of the current Benefit Year.

b) **Specialty Care Practitioner (SCP)**
If You are undergoing a current course of treatment with an SCP and Your SCP's relationship with NHP ends, then NHP will treat Your SCP as a Participating Practitioner for the remainder of the course of treatment or 90 Days, whichever is shorter. A course of treatment could include, but is not limited to, the following.

i. A doctor visit or hospital stay with documented changes in a therapeutic regimen for an acute illness. This is within 21 Days prior to the plan Effective Date or the health care Provider's termination date
ii. Recent major surgeries still in the follow-up period, which is generally six to eight weeks
iii. Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant
iv. Trauma
v. Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction
vi. "High risk" pregnancy if mother's age is 35 years or older, or patient has or had;
    1. Early delivery (three weeks) in previous pregnancy
    2. Gestational diabetes
    3. Pregnancy induced hypertension
    4. Multiple inpatient admissions during this pregnancy

c) **Maternity Care Practitioner**
If You are pregnant and Your Maternity Care Practitioner's relationship with NHP ends before You are past Your first trimester of pregnancy, NHP shall treat Your Maternity Care Practitioner as a Participating Provider for 90 Days. If You are pregnant and in Your second or third trimester of Your pregnancy and Your Maternity Care Practitioner's relationship with NHP ends, NHP will treat Your Maternity Care Practitioner as a Participating Provider through the birth of Your child and for Your post-partum care. A Maternity Care Practitioner will be covered in accordance with state law.

Newly effective Members in their third trimester of pregnancy (the third trimester starts at 26 weeks gestation) may continue to receive obstetrical care from their Non-Participating Practitioner or Non-Participating Provider at their In-Network Benefit level if the care is Prior Authorized. Prior Authorization of Non-Participating obstetrical services does not extend to care for the infant.

A covered person in their first or second trimester (starting at conception through 25 completed weeks gestation) upon initial enrollment must transition to a Participating Provider and/or Practitioner if enrolled in an HMO plan.

INITIAL CLAIMS

NHP processes Claims according to applicable state and federal time frames. Your Providers will file most Claims. When You personally file a Claim, You must provide all information reasonably necessary to process the Claim. This will help NHP process Your Claim quickly. For

questions on how to submit a Claim please contact Member Experience at the number on the back of Your ID card.

Questions about Benefits, eligibility or the circumstances under which NHP pays Benefits are not Claims. For example, a question about whether Your Dependent is eligible for a particular treatment is not a Claim.

PAYMENT
NHP pays medical insurance Benefits (after satisfaction of the annual Deductible), subject to all the terms, conditions, limitations and exclusions and any other Riders and/or Amendments attached to the Policy.

COOPERATION
Each Member claiming Benefits under this Plan must give Us any facts We need to determine Benefits payable. If You do not provide Us the information, Your Claim for Benefits will be denied.

REINSTATEMENT
If this Policy lapses for nonpayment of Premium and, within one year after the lapse, NHP accepts without reservation a Premium payment, this Policy will be reinstated as of the date of the acceptance. There is no acceptance without reservation if NHP delivers or mails a written statement of reservations within 45 Days after receipt of the payment.

INCONTESTABILITY
No statement made by an applicant in the application for this Policy, except Fraudulent or intentional misrepresentations of material fact, will be a basis for rescission or reformation of this Policy or denial of a Claim for loss incurred after the coverage has been in effect for two years. If this Policy is rescinded it means it was never in effect. Any Claims paid prior to the rescission must be paid back to NHP.

OFFICE OF THE COMMISSIONER OF INSURANCE

ARTICLE XII ~ OFFICE OF THE COMMISSIONER OF INSURANCE

To contact the Network Health Member Experience Team, call the telephone number listed on the back of Your ID card. If You prefer, You may send a secure message through Your Member portal at **login.networkhealth.com**.

You may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency that enforces Wisconsin's insurance laws, to file a Complaint. You can file a Complaint electronically with the OFFICE OF THE COMMISSIONER OF INSURANCE at its website at **www.oci.wi.gov** or by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

DEFINED TERMS

ARTICLE XIII ~ DEFINED TERMS

The following words and phrases shall have the meanings stated below. The following definitions are not an indication that charges for care, supplies or services are eligible for payment under the Plan. In fact, they may be used to identify ineligible expenses. Please refer to the appropriate sections of this document for information regarding coverage and exclusions.

ABUSIVE PRACTICES

Practices that, either directly or indirectly, result in unnecessary costs to the health care programs. Abuse includes any practice inconsistent with providing patients with Medically Necessary services meeting professionally recognized standards. Examples of abuse include:

a) Billing for unnecessary medical services
b) Charging excessively for services or supplies
c) Misusing codes on a Claim, such as upcoding or unbundling

ACCIDENT (ACCIDENTAL)

An occurrence which is:

a) Unforeseen; and,
b) Is not due to, or contributed to by, a Sickness or disease of any kind; and,
c) Causes Injury.

ACTIVITIES OF DAILY LIVING

Basic self-care tasks an individual does on a day-to-day basis, which are fundamental in caring for oneself and maintaining independence. These include, but are not limited to:

a) Bathing;
b) Dressing;
c) Toileting;
d) Transferring, which is moving out of bed, a chair, a wheelchair, a tub or a shower;
e) Mobility;
f) Eating;
g) Continence, which is voluntary maintaining control of bowel or bladder; in the event of incontinence, maintaining a reasonable level of personal hygiene.

ADVERSE BENEFIT DETERMINATION

Any of the following:

a) Denial, reduction or termination of Benefits;
b) Limitation of a Covered Service;
c) Failure to provide or make payment (in whole or in part) for a Benefit based on a determination of a person's eligibility to participate in the Plan;
d) Reduction or denial of a Claim based on utilization review, experimental or investigational treatments and Medical Necessity or appropriateness.

ALLOWABLE EXPENSE

Amounts paid for Covered Services which meet all requirements for coverage under the plan, including that it be reasonable, usual and customary and Medically Necessary. All Allowable Expenses are subject to Benefit maximums, cost sharing, limitations and exclusions.

DEFINED TERMS

ALLOWED AMOUNT
Maximum amount on which payment is based for covered health care services. If Your Practitioner and/or Provider charges more than the Allowed Amount, You may have to pay the difference. (See Balance Billing.) For Out-Of-Network charges refer to Maximum Out-of-Network Allowable Fee.

ALTERNATE FACILITY
A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

a) Surgical services
b) Emergency Health Services
c) Rehabilitative, laboratory, diagnostic or therapeutic services

An Alternate Facility may also provide Mental Health Services or services for Substance Abuse Disorders on an outpatient or Inpatient basis.

AMBULATORY SURGICAL CENTER
Any public or private state licensed establishment that operates exclusively for the purpose of providing surgery to patients not requiring hospitalization. The patient is admitted to and discharged from the facility within the same working day as the facility does not provide overnight services and accommodations.

AMENDMENT
Any attached written description of additional or alternative provisions to this document. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions , except for those specifically amended.

ANCILLARY FEE
An additional amount You are charged to fill a prescription when You or the Practitioner substitute a brand-name Drug for an available generic Drug. When generic substitution conflicts with state regulations or restrictions the pharmacist must gain approval from the prescriber to use the generic equivalent. ACA Preventive Drugs may be exempt from the Ancillary Fee when a generic version has been tried, the Practitioner indicates the brand name product is Medically Necessary and Prior Authorized for the $0 cost share has been approved.

APPEAL
A request for an Adverse Benefit Determination or Coverage Denial Determination to be reviewed again. See also Grievance.

BALANCE BILLING
When a Practitioner or Provider bills You for the difference between the charged and the Allowed Amount. For example, if the Practitioner's or Provider's charge is $100 and the Allowed Amount is $70, the Practitioner or Provider may bill You for the remaining $30. A Participating Provider may not Balance Bill You.

BENEFIT YEAR
The 12-month period during which yearly plan design features, such as the Deductible, Out-of-Pocket Limit, and specific Benefit maximums, accumulate.

BENEFIT(S)
Your right to payment for Covered Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions in this document, the Summary of Member Responsibility Table and any attached Riders and/or Amendments.

CHELATION THERAPY
A treatment that uses special Drugs that bind to heavy metals, like lead or mercury, in Your blood, and remove them through Your urine.

CLAIM
A request for payment or reimbursement for health care services in accordance with NHP's procedures for filing Claims.

COINSURANCE
A percentage of the Allowed Amount You must pay for Covered Services after the Deductible is met, if applicable. NHP pays the rest of the Allowed Amount. The Summary of Member Responsibility Table sets out what, if any, Coinsurance You must pay.

COMPLAINT
A verbal or written expression of any dissatisfaction with NHP or its contracted Providers.

CONFINEMENT
An admission as an Inpatient or outpatient to a Hospital, Residential Treatment Facility, Skilled Nursing Facility or licensed Ambulatory Surgical Center on the advice of Your Practitioner; or the time spent receiving Emergency Health Services for Illness or Injury in a Hospital. Hospital swing bed and Hospital sub-acute Confinement is considered the same as Confinement in a Skilled Nursing Facility. If You are transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement.

CONGENITAL ANOMALY
A physical Developmental defect that is present at the time of birth.

COPAYMENT
A charge stated as a set dollar amount that You are required to pay directly to the Provider for certain Covered Services. The Summary of Member Responsibility Table sets out what, if any, Copayment You must pay and will also indicate if the Copayment would apply to the plan Deductible and/or Out-Of-Pocket Limits.

COSMETIC PROCEDURES
Any surgery or medical treatment undertaken to change or improve Your appearance or self-esteem, without significantly improving physiological function as determined by NHP such as plastic surgery to enhance Your appearance. Cosmetic Procedures do not treat a bodily Injury, Illness or functional bodily impairment.

COVERAGE DENIAL DETERMINATION
An Adverse Benefit Determination, an Experimental Treatment Determination or the rescission of this Policy.

COVERED SERVICE(S)
A Medically Necessary service, treatment or supply, meant to improve a condition or Your health, which is eligible for coverage. When more than one treatment option is available, and one option is no more effective than another, the Covered Service is the least costly option that is no less effective than any other option.

CUSTODIAL CARE
The provision of room and board, nursing care, personal care or other care designed to assist You in the Activities of Daily Living. Custodial Care is not likely to improve Your medical condition. Care provided when You have reached the maximum level of recovery is Custodial Care. Such care is Custodial even if the level of maintenance care requires services of some skilled health professionals. Custodial Care also includes rest cures, respite care and home care provided by Family Members. NHP's Medical Director will determine whether care qualifies as Custodial Care.

DAYS
Any reference to "Days" means calendar days, unless otherwise noted.

DEDUCTIBLE
The amount stated in the Summary of Member Responsibility Table that You or all Members of Your family are required to pay each Benefit Year before any payment for expenses is made by NHP. NHP will calculate the Deductible based upon the total amount of Allowable Expenses incurred during a Benefit Year. The Deductible does not include any amount that exceeds Eligible Expenses. Only charges for Covered Services satisfy the Deductible.

DEPENDENT(S)
The Policyholder's legal spouse and/or child, or the child of the Policyholder's spouse. The individual must also be a citizen of the United States or a resident legal alien.

The term child includes any of the following:
a) A natural child;
b) A stepchild;
c) A legally adopted child;
d) A child for whom legal guardianship has been awarded to the Policyholder the Policyholder's spouse; or
e) A child of a covered Dependent child (grandchild) until the covered Dependent child, who is the parent, turns 18.

A child listed above must be under 26 years of age.

A Dependent will also include a child aged 26 or older who meets the following criteria:
a) The child is unable to hold a self-sustaining job due to intellectual disability or physical handicap;
b) The child is chiefly dependent on You for support and maintenance;
c) The child's incapacity existed before he or she reached age 26;
d) Your family coverage remains in force; and
e) The child is unmarried.

Written proof of the child's incapacity and dependency must be provided to Us within 31 Days of the child attaining age 26, and at any time thereafter, but no more frequently than annually after the initial two-year period following the attainment of age 26. You must notify Us immediately of an end to the incapacity or dependency.

A Dependent also includes an adult child who meets all of the following:

a) The child is a Full-Time Student, regardless of age, attending an accredited vocational, technical or adult education school or an accredited college or university; and
b) The child was under age 27 and called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while attending, on a full-time basis, an institution of higher education.

A Dependent who is on active duty with the military service, including the National Guard or Reserves, for more than 30 Days is not an eligible Dependent. We may require proof of the adult child's Full-Time Student enrollment on an as-needed basis.

DEVELOPMENTAL OR LEARNING DISABILITY OR DELAY
Any condition that interrupts or delays the sequence and rate of normal growth, development and maturation. The condition may be due to:

a) Congenital abnormality;
b) Trauma;
c) Deprivation; or
d) Disease.

DIAGNOSIS
The act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of patient history, examination and review of laboratory test result data.

DIAGNOSTIC SERVICE
An examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of an Illness or Injury. A Provider must order the Diagnostic Service.

DRUG
An FDA-approved prescription medicine, preventive medicine or medicine covered under the ACA, intended for human use in the Diagnosis, cure, alleviation, treatment or prevention of disease, which is listed with approval in the United States Pharmacopeia, National Formulary, American Hospital Formulary Service, Micromedex or National Comprehensive Cancer Network. It must be legally obtained and only dispensed by a licensed Provider. These products are approved under a New Drug Application, Amended New Drug Application, Biological License Application or under Biosimilar regulations. It does not include medicinal foods, devices, components, parts or accessories of devices.

DURABLE MEDICAL EQUIPMENT
Equipment that meets all the following criteria:

a) Can withstand repeated use;
b) Is not disposable;

c) Is used to serve a medical purpose with respect to treatment of a Sickness, bodily Injury or their symptoms rather than being primarily for comfort or convenience;
d) Is generally not useful to You in the absence of an Illness, bodily Injury or their symptoms; and
e) Is not implantable within the body.

EFFECTIVE DATE
The date that a Policyholder, or any qualified Dependent, becomes enrolled and entitled to the Benefits specified in this Policy, as shown in the records of NHP.

ELIGIBLE EXPENSES
Expenses that may be considered for processing toward Deductible or payment if the services meet all of the following:
a) Are Medically Necessary and not experimental/investigational (except as described in the Routine Patient Care for Approved Clinical Trial section);
b) Received while this Policy is in effect;
c) The person who receives Covered Services meets all eligibility requirements specified in this Policy; and
d) Appropriate Proof of Loss was submitted timely.

EMERGENCY
A medical condition which may manifest itself by acute symptoms of sufficient severity, including severe pain, which leads 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; or
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.

An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness and hemorrhage.

EMERGENCY HEALTH SERVICES
Services and supplies necessary for the treatment of an Emergency including:
a) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency medical condition; and
b) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

ESSENTIAL HEALTH BENEFITS (EHB)
A set of ten categories health insurance plans must cover under ACA. These include doctors' services, Inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, Mental Health Services and more. Not all services under these categories are

considered an EHB, which vary by state. Only charges for EHB Covered Services are required under the ACA to apply toward the Deductible and Out-of-Pocket Limit.

EXPERIMENTAL TREATMENT DETERMINATION
NHP's determination that each of the following applies:

a) A proposed treatment has been reviewed by or on behalf of NHP;
b) The treatment was determined to be Experimental;
c) NHP denied the treatment or payment for the treatment.

FAMILY MEMBER
A person who is related to the Member as a spouse, parent, grandparent, stepparent, step grandparent, siblings, step siblings, children, stepchildren and grandchildren, whether the relationship exists by virtue of blood or in law.

FRAUDULENT
Fraudulent services typically include knowingly submitting, or causing to be submitted, false Claims or making misrepresentations of fact to obtain a health care payment for which a Provider would otherwise not be entitled. Examples of fraud include the following.

a) Billing for appointments the patient failed to keep.
b) Knowingly billing for services at a level of complexity higher than services actually provided or documented in the file.
c) Knowingly billing for services and/or supplies not provided, including falsifying records to show delivery of such items.
d) Misrepresenting who provided the services, altering Claim forms, electronic Claim records or medical documentation.

FULL-TIME STUDENT
A Dependent who is enrolled in at least 12 credits per semester, or as defined by the institution the student is attending.

GRIEVANCE
A written or electronically submitted expression of dissatisfaction with NHP's administration, Claims practices or provision of services submitted by or on behalf of a Member.

HABILITATIVE SERVICES
Health care services that help a person keep, learn or improve skills and functioning for daily living. An example of this is therapy for a child who isn't walking or talking at the expected age. Habilitative Services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH MAINTENANCE ORGANIZATION (HMO)
A type of health insurance plan that limits coverage to care from Providers who contract with the HMO. It won't cover Out-of-Network care except in an Emergency. HMOs often provide integrated care and focus on prevention and wellness.

HOME HEALTH AGENCY
An agency or organization which provides a program of Home Health Care and which:

a) Is a federally certified Home Health Care Agency and approved as such under Medicare;

b) Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required; or
c) Meets all the following requirements:
    i. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
    ii. It has a full-time administrator;
    iii. It maintains written records of services provided to the patient;
    iv. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available; and
    v. Its employees are bonded and it provides malpractice insurance.

HOME HEALTH CARE
Care and treatment You need, but Your immediate family is not able to provide or may only provide with undue hardship. Your immediate family includes other persons who reside with You. A state licensed or Medicare certified Home Health Agency or certified rehabilitation agency must manage the care. Home Health Care consists of one or more of the following:
a) Part-time or intermittent nursing care;
b) Physical, respiratory, speech, occupational therapy;
c) Nutritional counseling;
d) Part-time or intermittent home health aide services;
e) Medical supplies, drugs;
f) Laboratory services;
g) Evaluation of the need for and the development of a plan for home health services.

HOSPICE
Services within an integrated program, the primary purpose of which is to provide comfort and support to the terminally ill and their families on a 24-hour-a-day, seven-days-a-week basis. Services include physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for Your immediate Family Members while You are receiving Hospice care. The Provider may also offer skilled nursing services, dietary counseling, physician services, physical or occupational therapist, home health aide services, pharmacy services and Durable Medical Equipment.

A licensed public agency or private entity must provide the services. Services may be provided in a Hospice facility housed in a Hospital, a separate Hospice unit or in the patient's home. A Hospice facility housed in a Hospital must be in a separate and distinct area.

HOSPITAL
A facility that is appropriately licensed and operated as required by law and meets the following:
a) Primarily engaged in providing health services, on an Inpatient basis, for the acute care and treatment of injured or sick individuals.
b) Care is provided through medical, Diagnostic Service and surgical facilities, by or under the supervision of a staff of Practitioners.
c) Licensed nurses provide 24-hour-a-day nursing services.

A Hospital is not a state tax supported Institution, primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

ILLNESS
A disruption in function or structure of Your body that causes physical signs or symptoms. An Illness, if left untreated, will cause the health of Your body structure or system to deteriorate. Pregnancy is included in this definition.

INFERTILITY
The failure of a couple to conceive a pregnancy after trying to do so for at least one full year.

INJURY
Bodily damage, other than Sickness, including all related conditions and recurrent symptoms resulting from an Accident.

IN-NETWORK
The Practitioners and Providers NHP has contracted with to provide Covered Services.

INPATIENT REHABILITATION FACILITY
A Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an Inpatient basis, as licensed by law.

INPATIENT STAY
Care as part of an admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility. Observation status is not considered Inpatient.

INSTITUTION
A facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Agency, or any other such facility the Plan approves.

MAINTENANCE THERAPY
Ongoing therapy for which only minimal rehabilitative gains can be shown. Such therapy is provided after the acute phase of a bodily Injury or Illness has passed. Therapy provided after a patient's recovery reaches a plateau or slows or ceases entirely. NHP determines that therapy is Maintenance Therapy by reviewing Your case history or the treatment plan the Provider submits.

MATERNITY CARE PRACTITIONER
A duly licensed obstetrician and gynecologist or other maternity care Providers who are licensed, registered or certified to perform maternity care in accordance with state law.

MAXIMUM ALLOWABLE FEE
The maximum amount allowed for charges for Covered Services based upon:

a) Our methodology guidelines;

b) Pricing guidelines of any third party that is responsible for repricing a Claim;
c) The negotiated rate determined by Us in accordance with the applicable contract between Us and a health care Provider or Practitioner; or
d) Maximum Out-of-Network Allowable Fee.

The Maximum Allowable Fee may be less than the amount billed.

Upon written or oral request from You for Our Maximum Allowable Fee for a health care service and if You provide Us with the appropriate billing code that identifies the health care service (e.g., CPT codes, ICD-9 or ICD-10 codes, or Hospital revenue codes) and the heath care Provider's or Practitioner's estimated fee for that health care service, We will provide You with any of the following:

a) A description of Our specific methodology including, but not limited to, the following:
   i. The source of the data used, such as Our Claims experience, an expert panel of Providers or Practitioners, or other sources;
   ii. The frequency of updating such data;
   iii. The geographical area used;
   iv. If applicable, the percentile used in determining the Maximum Allowable Fee; and
   v. Any supplemental information used in determining the Maximum Allowable Fee.
b) The Maximum Allowable Fee determined by Us under Our guidelines for a specific health care service provided to You. That may be in the form of a range of payments or maximum payment.

MAXIMUM OUT-OF-NETWORK ALLOWABLE FEE
The maximum amount We reimburse for Covered Services provided by a Non-Participating Provider, or a Non-Participating Practitioner.

MEDICAL DIRECTOR
The physician, licensed to practice medicine in the State of WI, who is employed either directly, or by contract with NHP. The Medical Director makes authorization decisions including the determinations of not medically necessary and experimental/investigational. The Medical Director is also involved in the development, participation and oversight of our population health clinical and quality programs.

MEDICALLY NECESSARY (MEDICAL NECESSITY)
Health care services or supplies that meet all the following:

a) Are appropriate and necessary to identify, diagnose or treat a bodily Injury or Illness;
b) Are appropriate for and consistent with Your Diagnosis in accordance with generally accepted standards of the medical community;
c) Are not primarily Custodial Care, or Maintenance Therapy
d) Are provided in the least intense, most cost-effective setting or manner needed for Your bodily Injury or Illness;
e) Are provided in an institution and could not have been provided at a lower level of care;
f) Are not primarily educational in nature;
g) Are not for Your vocation, comfort, convenience, exercise, physical fitness or recreation;
h) Are not to improve Your appearance or for the convenience of the Provider.

DEFINED TERMS

MEDICARE
Title XVIII (Health Insurance Act for the Aged) of the U.S. Social Security Act, as amended. A health insurance program for people:

a) Age 65 or older.
b) Under age 65 with certain disabilities.
c) Of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

MEMBER
An individual who is eligible and enrolled to receive Covered Services.

MENTAL HEALTH DISORDERS
A mental or emotional disease or disorder to such an extent that it requires care and treatment for personal welfare, or the welfare of others, or the community. Mental Health Disorders include psychiatric Illnesses classified as a Mental Health Disorder in the current edition of International Classification of Diseases, listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

Mental disorder does not include autism spectrum disorder.

MENTAL HEALTH SERVICES
Covered Services for the Diagnosis and treatment of Mental Health Disorders. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Service.

NHP
Network Health Plan.

NON-PARTICIPATING, PROVIDER, PRACTITIONER, FACILITY OR HOSPITAL
Facilities, Providers and suppliers who do not have a contract with NHP to provide Covered Services.

OUT-OF-NETWORK
Practitioners or Providers who have not contracted with NHP for reimbursement at a negotiated rate.

OUT-OF-POCKET LIMIT
The maximum amount stated in the Summary of Member Responsibility Table, which can be paid by You or between all Members of your family, each Benefit Year, including annual Deductible, Coinsurance amounts, Copayments and Ancillary Fees for prescription Drugs. Once the Out-of-Pocket Limit is reached, the covered percentage will increase to 100 percent of the Allowable Expense (unless specifically stated otherwise in the Summary of Member Responsibility Table) for the rest of that Benefit Year. Expenses incurred for health care services not covered by Us, Your Premium, or expenses over and above the Maximum Allowable Fee (Balance-Billed charges) do not count towards the Out-of- Pocket Limit.

PALLIATIVE CARE
Services focused on preventing or relieving pain and suffering. The goal is to improve comfort and quality of life for people with a life-threatening or life-limiting Illness whether or not they are receiving active treatment. Palliative Care may include, but is not limited to, services for pain, fatigue, anxiety, difficulty breathing and nausea.

PARTICIPATING PROVIDER, PRACTITIONER, FACILITY OR HOSPITAL
Practitioners, facilities, Providers and suppliers who have a contract with NHP to provide Covered Services for discounted fees which they have agreed to accept as payment in full.

POLICY
This document which describes the health care services or supplies which are Covered Services, as well as the requirements which must be met in order to receive payment for those Covered Services.

POLICYHOLDER
The person to whom this Policy is issued, not a Dependent. The person must reside in NHP's Service Area.

POST-SERVICE CLAIM
A Claim for Covered Services that have been provided.

PRACTITIONER
An individual licensed by the state in which they practice within the scope of their license to furnish health care. A Practitioner may be a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Podiatrist, Audiologist, Physician Assistant, Registered Nurse Midwife, Nurse Practitioner or Chiropractor.

PREMIUM
The monthly fees charged by NHP to the Policyholder for the Benefits set out in this Policy.

PRE-SERVICE CLAIM
A request for a Prior Authorization to cover all or part of the services to be provided.

PREVENTIVE SERVICES
Certain services required to be offered by NHP in accordance with the Patient Protection and Affordable Care Act (PPACA), without cost sharing when they are received from a Participating Provider.

PRIMARY CARE PRACTITIONER (PCP)
A Practitioner specializing in internal medicine, general practice, family practice, obstetrics/gynecology, pediatrics or other health care Provider designated by NHP, who You have selected to provide and coordinate Your health care services.

PRIOR AUTHORIZATION (PRIOR AUTHORIZED)
The process of obtaining NHP's approval before health care services are rendered, for a variety of purposes, including to determine Your Eligibility, whether Benefits are available, whether the service is Medically Necessary and the location and appropriateness of services.

PRIVATE DUTY NURSING
Nursing care provided on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true.

a) No skilled services are identified.
b) Skilled nursing resources are available in the facility.
c) The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

The service is provided by an independent nurse who is hired directly by You or Your family. This includes nursing services provided on an Inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

PROVIDER(S)
Any Practitioner, facility, Skilled Nursing Facility, Home Health Agency or other duly licensed institution or health professional who is licensed, registered or certified by the state in which they practice; or health care entity, regardless of whether or not they are contracted with NHP to provide Covered Services.

QUALIFIED HEALTH PLAN (QHP)
An insurance plan that's certified by the Health Insurance Marketplace®, provides essential health benefits, follows established limits on cost sharing (like Deductibles, Copayments and Out-of-Pocket maximum amounts), and meets other requirements under the ACA. All qualified health plans meet the ACA requirement for having health coverage, known as "minimum essential coverage."

REASONABLE
Fees for services or supplies that in NHP's discretion, are necessary for the care and treatment of Illness or Injury. To be Reasonable, service(s) and/or fee(s) must also follow generally accepted billing practices for unbundling or multiple procedures. NHP retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to Us. NHP reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by Us, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment.

RECONSTRUCTIVE PROCEDURES
A procedure to improve or repair an abnormal condition of a body part.

REHABILITATION SERVICES
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of outpatient settings.

RESIDENTIAL TREATMENT FACILITY
A facility which provides a program of effective Mental Health and Substance Abuse Services treatment and meets all the following requirements:

a) It is established and operated in accordance with applicable state law for residential treatment programs.
b) It provides a program of treatment under the active participation and direction of a Practitioner.
c) It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation.
d) It provides at least the following basic services in a 24-hour per day, structured environment:
    i. Room and board.
    ii. Evaluation and Diagnosis.
    iii. Counseling.
    iv. Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

RIDER
Any attached written description of additional Covered Services. Riders are subject to all conditions, limitations and exclusions except for those that are specifically amended in the Rider.

ROOM AND BOARD
A Hospital's charge for: Room and complete linen service; dietary service including all meals, special diets, and dietary consultation; all general nursing services; and other conditions of occupancy which are Medically Necessary.

ROUTINE FOOT CARE
Routine foot care includes:
a) Cutting or removing corns and calluses.
b) Trimming, cutting or clipping nails.
c) Hygienic or other preventive maintenance, like cleaning and soaking your feet.

ROUTINE PATIENT CARE
All health care services, items and Drugs that are typically provided in health care, including those provided to during the course of treatment in a cancer trial (all phases) for a condition or any of its complications and those services are consistent with the usual and customary standard of care including the type and frequency of any diagnostic modality.

Routine Patient Care does not include:
a) The health care service, item or investigational drug that is the subject of the cancer clinical trial;
b) Any health care service, item or Drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member;
c) Investigational Drugs or devices that have not been approved for market by the FDA;
d) Transportation, lodging, food or other expenses associated with travel to or from a facility providing the cancer clinical trial;
e) Any services, items or Drugs provided by the cancer clinical trial sponsors free of charge;
f) Any services, items or Drugs eligible for reimbursement by a party other than the insurer.

SEMI-PRIVATE ROOM
A room with two or more beds. When an Inpatient Stay is a Covered Service, the Benefit is for the cost of a Semi-Private Room and a private room is a Benefit only when Medically Necessary or when a Semi-Private Room is not available.

SERVICE AREA
The geographic area where We act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency and for which NHP is licensed by the appropriate regulatory agencies. Contact Member Experience at the number on the back of your ID card or visit networkhealth.com at https://networkhealth.com/about/service-area to see the exact geographic area We serve. The Service Area may change from time to time.

SICKNESS
A physical Illness or disease. The term Sickness as used in this document includes Mental Health and Substance Abuse Disorders.

SKILLED NURSING FACILITY
A facility that:

a) Is primarily engaged in providing skilled nursing care and related services on a 24 hour a day basis to Inpatients requiring medical or skilled nursing care; and,
b) Is qualified to participate under Medicare; and,
c) Is properly licensed.

SPECIALTY CARE PRACTITIONER (SPECIALIST)
A Practitioner who has a majority of their practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

SUBSTANCE ABUSE DISORDER
Alcohol, Drug and chemical abuse, overuse or dependency disorders listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services or disorders are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service.

SUMMARY OF MEMBER RESPONSIBILITY TABLE
The document outlining Your cost-sharing terms and other terms of the medical and pharmacy Benefits plan.

TELEMEDICINE
Medical services provided using two-way, real time interactive communication between You and the Provider at a remote site. This electronic communication means the use of interactive telecommunications equipment that includes audio and/or video. Telemedicine does not include email messages, text messages, fax or mail.

TOTAL DISABILITY OR TOTALLY DISABLED
A person is Totally Disabled when, due to an Illness or Accidental injury:

a) The person is the Policyholder who is unable to engage in any occupation.

b) The Policyholder may not engage in any gainful occupation during a period of Total Disability;
c) The individual is a covered person who is not the Policyholder and who is unable to engage in any normal activity of a person in good health of the same age and gender.

Your Practitioner will determine whether You are Totally Disabled in conjunction with the NHP Medical Director.

TRANSITIONAL CARE
Mental Health and Substance Abuse Disorders provided in a less-restrictive manner than Inpatient Hospital services but more intensive than outpatient services. This includes residential treatment programs for alcohol and drug dependence in addition to adult, child and adolescent day treatment.

UNPROVEN, EXPERIMENTAL, INVESTIGATIONAL OR FOR RESEARCH PURPOSES
Treatments, procedures, services, supplies, drugs, devices or technologies that are not known to be safe or effective or that are used in a way that deviates from generally accepted standards of the U.S. medical community. NHP's Medical Director or designee will determine, in its sole discretion, if a Treatment qualifies.

URGENT CARE
Care for the sudden onset of bodily Injury or Illness that does not qualify as an Emergency. Services for care that You need before You can set up a routine doctor visit are Urgent Care. Examples of Urgent Care situations are closed fractures, non-severe bleeding, minor cuts and burns.

URGENT CARE FACILITY
A facility that provides for the delivery of Urgent Care Services. An Urgent Care Facility generally provides unscheduled, walk-in care. An Urgent Care Facility may be Hospital-based or non-Hospital based.

VIRTUAL VISITS
Use of interactive secure audio and video telecommunications systems that permit real-time communication between a patient, who is not physically in a facility, clinic or Hospital, and a Provider who can report evaluation and management services. Virtual Visits allow Providers to diagnose symptoms, prescribe medication and send prescriptions for non-Emergency medical conditions. NHP has partnered with a Provider of online visit care to offer services 24 hours a day, seven days a week, 365 days a year.

WASTEFUL
The use, consumption or overutilization of services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources. Examples of waste include:
a) Billing or dosage errors
b) Incorrect bundling of charges
c) Unnecessary or duplicative services

d) Excessive units

This page has been added for sign-off purposes only, this information will not be included in any of the policy documents.

Network Health Plan

Individual Health Maintenance Organization (HMO) Supplemental Benefits Rider

Network Health Plan (NHP) has amended the Policy to which this Rider is attached to provide coverage for designated Dental and Adult Vision Care services. The Policy is amended as follows.

ARTICLE V ~ BENEFIT PROVISIONS is hereby amended to add the benefits outlined below.

DENTAL SERVICES – ANNUAL EXAM

NHP will cover two (2) exams, two (2) cleanings and one (1) bitewing x-ray annually per member through a reimbursement process. After receiving services, members will complete the dental reimbursement form and submit it to Employee Benefits Corporation, Inc. (EBC) in order for coverage to apply. Reimbursement forms must be submitted within 120 days from date of service. To locate the dental reimbursement form, log in to Your Network Health member portal at **login.networkhealth.com** and click on **My Materials or** call our Member Experience team at the phone number on the back of Your member ID card.

a) Two (2) oral exams per year (covered CDT codes D0120, D0140, D0145, D0150, D0160 and D0180)
b) Two (2) cleanings per year (covered CDT codes D1110, D1120 and D4346)
c) One (1) bitewing x-ray per year (covered CDT codes D0270, D0272, D0273, D0274 and D0277)

VISION CARE SERVICES – ADULT

NHP will cover one (1) routine vision exam with an eye refraction and provide an allowance up to $100 on hardware for adults aged 19 and older through our partnership with EyeMed®. The exam may screen for eye disorders and assess the need for prescription corrective or contact lenses. Services will only be covered if received from an EyeMed® Participating Practitioner. To search for an EyeMed® Participating Practitioner, visit **networkhealth.com/individual/vision-eyemed**. Claims must be submitted to EyeMed® for coverage to apply.

a) One (1) routine vision exam with an eye refraction per year
b) Frames and lenses
    i. Up to a $100 allowance total for frames, lenses and lens options and a 20 percent (20%) discount for remaining balance over $100; or
    ii. Up to a $100 allowance total for conventional contact lenses and a 15 percent (15%) discount for remaining balance over $100; or
    iii. Up to a $100 allowance total for disposable contact lenses with no discount for remaining balance over $100.

Discrimination is Against the Law

Network Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Network Health does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Network Health:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Network Health's Compliance Officer.

If you believe that Network Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Network Health
Attn: Compliance Officer
1570 Midway Place
Menasha, WI 54952
Phone: 855-275-1400
(TTY users should call 800-947-3529)
Email: compliance@networkhealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health's compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Network Health's website: networkhealth.com.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-275-1400 (TTY: 800-947-3529) or speak to your provider.

Albanian: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 855-275-1400 (TTY: 800-947-3529) ose bisedoni me ofruesin tuaj të shërbimit.

Arabic: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات تنبيه: كما تتوفر وسائل مساعدة وخدمات المساعدة اللغوية المجانية. مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. أو اتصل على الرقم 1400-275-855 (3529-947-800) تحدث إلى مقدم الخدمة.

Chinese: 如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-275-1400（文本电话：800-947-3529）或咨询您的服务提供商。

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-275-1400 (TTY : 800-947-3529) ou parlez à votre fournisseur.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-275-1400 (TTY : 800-947-3529) an oder sprechen Sie mit Ihrem Provider.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निः शु॒ भाषा सहायता सेवाएं उपल॒ होती हैं। सुलभ॒प्रारूपों में जानकारी प्रदान करने केलिए उपयु॒ सहायक साधन और सेवाएँ भी निः शु॒ उपल॒ 855-275-1400 (TTY : 800-947-3529) पर कॉल करें या अपने प्रदाता से बात करें।

Hmong: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 855-275-1400 (TTY : 800-947-3529) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Korean:한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-275-1400 (TTY : 800-947-3529) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Laotian: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ ເສຍຄ່າໃຫ້ທ່ານ. ມີ ເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ ເສຍຄ່າທີ່ ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນ ຮູບແບບທີ່ ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 855-275-1400 (TTY : 800-947-3529) ຫຼື ຕິດຕໍ່ຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Pennsylvania Dutch: Wann du Druwwel hoscht fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 855-275-1400 (TTY: 800-947-3529) uff odder schwetz mit dei Provider.

Polish: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-275-1400 (TTY : 800-947-3529) lub porozmawiaj ze swoim dostawcą.

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-275-1400 (TTY : 800-947-3529) или обратитесь к своему поставщику услуг.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-275-1400 (TTY : 800-947-3529) o hable con su proveedor.

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-275-1400 (TTY : 800-947-3529) o makipag-usap sa iyong provider.

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-275-1400 (Người khuyết tật: 800-947-3529) hoặc trao đổi với người cung cấp dịch vụ của bạn.